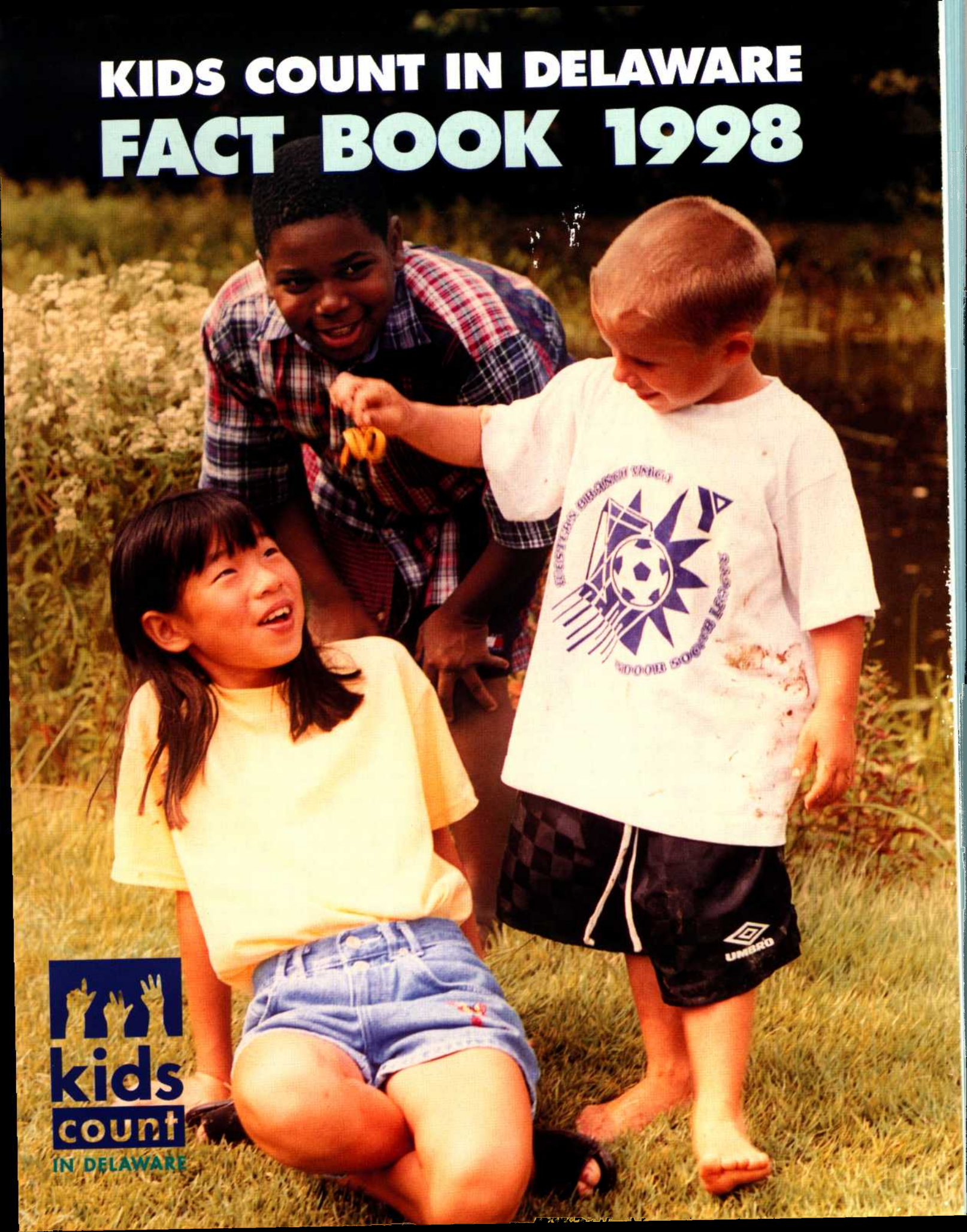
KIDS COUNT IN DELAWARE FACT BOOK 1998



kids count IN DELAWARE

Dear Friends,

As residents of the State of Delaware and stewards of future generations, we have a responsibility to care for all our state's children. The numbers, charts, and stories in this KIDS COUNT Fact Book speak to us—as well as speak for us— in our efforts to forge a healthier Delaware for young people.

These pages tell the story improving on a number of fronts—including a decline in infant mortality, and child poverty, as well as lower teen death rates. Other statistics bear witness to the fact that our work is far from complete as we strive to strengthen families from Talleyville to Selbyville.

As I travel throughout Delaware advocating for kids, I often quote a visionary who once said: "200 years from now, no one will remember the size of our bank account, the kind of car we drove, or the house we lived in. 200 years from now, the world will be a better place because we made a difference in the life of a child."

As I go through each day as your governor, I keep in mind my two young sons and dreams for their futures—a future filled with achievement, happiness, and success. I hope educators, policy makers, planners and residents will find ways to use this book to forge better lives for all our children.

Sincerely,

Tom Carper

Thomas R. Carper
Governor

Governor Carper with Glasgow High School teens who participated in the KIDS COUNT project "Kids Voices Count"

KIDS COUNT IN DELAWARE FACT BOOK 1998

Funded by the Annie E. Casey Foundation
with additional support from the State of Delaware

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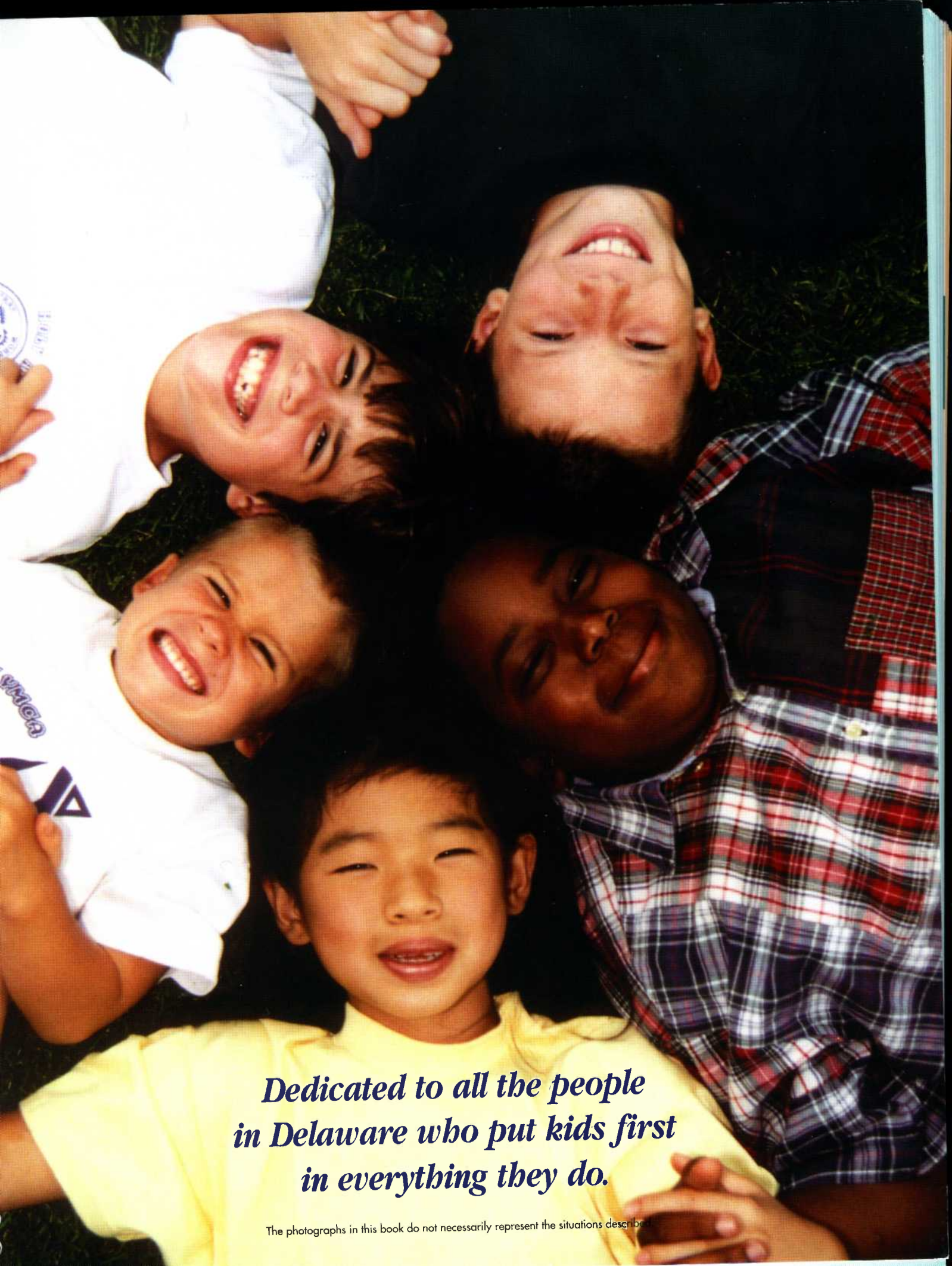
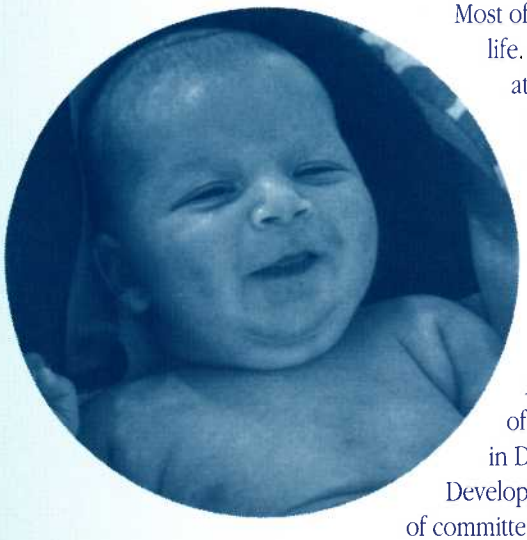
Thanks to the Birth to Three Program and Delaware State Housing Authority for the use of photographs, and a special thank you to the Delaware children featured in photographs on the cover and throughout the book.



Dedicated to all the people in Delaware who put kids first in everything they do.

The photographs in this book do not necessarily represent the situations described

A Message from KIDS COUNT in Delaware



Most of the 195,000 children and youth in Delaware benefit from a strong, healthy start in life. They are born to parents who have the time and resources to nurture them, they attend good schools and can read at grade level, they live in safe neighborhoods, and they know their family doctors by name. There are Delaware children, however, who have very different situations. Some children in our state are growing up in families that do not have the resources, skills, or opportunities to give children the basics for a good start in life. KIDS COUNT in Delaware keeps track of all our children and examines the myriad of situations in which they live and grow.

In this our fourth annual profile of Delaware's children, *KIDS COUNT in Delaware Fact Book 1998*, we look at some of the greatest challenges in the lives of our children and youth, aiming to create a holistic view of how children are faring in Delaware. Through this collaborative project housed at the Center for Community Development and Family Policy at the University of Delaware, led by a Steering Committee of committed and concerned children's advocates from the public and private sector, we bring together the best available data to measure the health, economic, educational and social well-being of children.

KIDS COUNT in Delaware is one of fifty-one similar projects throughout the United States funded by the Annie E. Casey Foundation. This initiative is based on the belief that the more the public and policy makers know about the status and needs of children, the greater the likelihood those needs will be addressed.

This edition of KIDS COUNT is combined with a new initiative of Governor Carper's Family Services Cabinet Council entitled *FAMILIES COUNT in Delaware* which expands upon the ten tracking indicators of the *National KIDS COUNT Data Book* to look at a broad range of indicators related to families in Delaware. We are pleased to present to you both KIDS COUNT and FAMILIES COUNT as a combined publication and believe that it represents a statewide commitment to monitor outcomes and show that both children and families do matter, do count, in this state.

What does KIDS COUNT in Delaware ask that you do to help the children of Delaware?

Challenge to parents:
- Stimulate your child's development from infancy on.
- Become involved in your child's school.
- Make sure your child receives routine health care.
- Spend more time together.

Challenge to communities:
- Make your community the best place in Delaware to raise a child.
- Join local organizations to improve schools, make neighborhoods safer, and support parents.

Challenge to Delaware:
- Make the health, education, and well-being of children the state's first priority and investment.

The result will be a better future for our children — and ultimately, for our state!

Nancy Wilson, Ph.D.
Chair
Steering Committee

Steven A. Dowshen, M.D.
Chair
Data Committee

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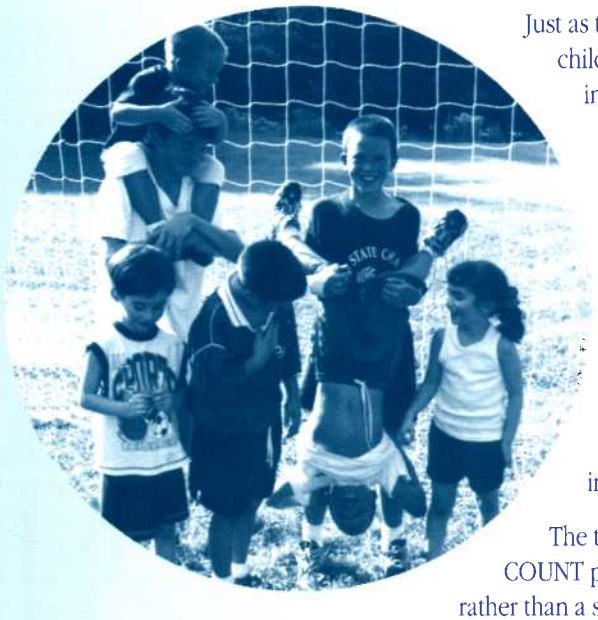
KIDS COUNT in Delaware



Just as the photographs in this book present a variety of faces of Delaware's children, the *KIDS COUNT in Delaware Fact Book 1998* presents a variety of indicators to portray a balanced perspective for considering their well-being. In addition to the ten indicators used by the Annie E. Casey Foundation's *KIDS COUNT National Data Book*, special emphasis has been placed on early care and education with expanded information concerning accessi-bility, affordability, quality and consumer awareness. Other areas such as alcohol, drug and tobacco use, women and children receiving WIC, free and reduced-priced school meals and newly-released asthma data based on hospitalizations continue to be reported. Several areas have been expanded with Impact Statements and sources for further information. Both the appendix of tables and the FAMILIES COUNT section contain supporting documentation for many of the graphs in the KIDS COUNT section.

The ten featured indicators in this book have been chosen by the national KIDS COUNT project because they provide a picture of the actual condition of children rather than a summary of programs delivered or funds expended on behalf of children. These indicators have three attributes:

- They reflect a broad range of influences affecting the well-being of children.
- They reflect experiences across developmental stages from birth through early adulthood.
- They are consistent across states and over time, permitting legitimate comparisons.

The featured indicators are:

Births to teens
Low birth weight babies
Infant mortality
Child deaths
Teen deaths by accident, homicide, and suicide
Juvenile violent crime arrests
Teens not graduated and not enrolled
Teens not in school and not working
Children in poverty
Children in one-parent households

Trends in Delaware

Delaware has seen improvements in five of the National KIDS COUNT indicators while there is cause for concern in four:

- ***The infant mortality rate, child death rate, teen deaths by accident, homicide, and suicide, high school dropouts, and teens not in school and not in the labor force indicators show improvement or are better than the national average.***
- ***The percentage of children in poverty remains below the national rate with little change in its recent trend.***
- ***Of concern are the increasing rate of births to teens, juvenile violent crime arrests, low birth weight babies, and children in one-parent households.***

Making Sense of the Numbers

The information on each indicator is organized as follows:

- Definition — a description of the indicator and what it means
- Impact — the relationship of the indicator to child and family well-being
- Related information — information in the appendix or in FAMILIES COUNT relating to the indicators

Sources of Data

The data are presented primarily in three ways

- Annual data for 1996
- Three-year and five-year averages through 1996 to minimize fluctuations of single year data and provide more realistic pictures of children's outcomes.
- Annual, three-year or five-year average data for a decade or longer to illustrate trends and permit long-term comparisons.

The data has been gathered primarily from:

- The Center for Applied Demography and Survey Research, University of Delaware
- Delaware Health Statistics Center, Delaware Health and Social Services
- Department of Education, State of Delaware
- Delaware State Data Center, Delaware Economic Development Office
- Statistical Analysis Center, Executive Department, State of Delaware
- Delaware Health and Social Services, State of Delaware
- U.S. Bureau of the Census
- National Center for Health Statistics, U.S. Department of Health and Human Services
- Delaware Population Consortium
- Family and Workplace Connection
- Department of Services for Children, Youth and Their Families, State of Delaware

Interpreting the Data

The KIDS COUNT Fact Book 1998 uses the most current, reliable data available. Where data was inadequate or unavailable, NA was used. For some data, only the decennial census has information at the county level.

Most indicators are presented as three- or five- year averages because rates based on small numbers of events in this state which has a relatively modest population can vary dramatically from year to year. A three- or five- year average is less susceptible to distortion. It is helpful to look at trends rather than at actual numbers, rates, or percentages due to the small numbers.

Accepted names for various racial and ethnic groups are constantly in flux and indicators differ in their terminology. KIDS COUNT has used the terminology reported by the data collection sources.

Fiscal Year Data: Most data presented here is for calendar years. Where data collected by state or federal authorities is available by school calendar year or fiscal year, the periods are from September to June or July 1 to June 30.

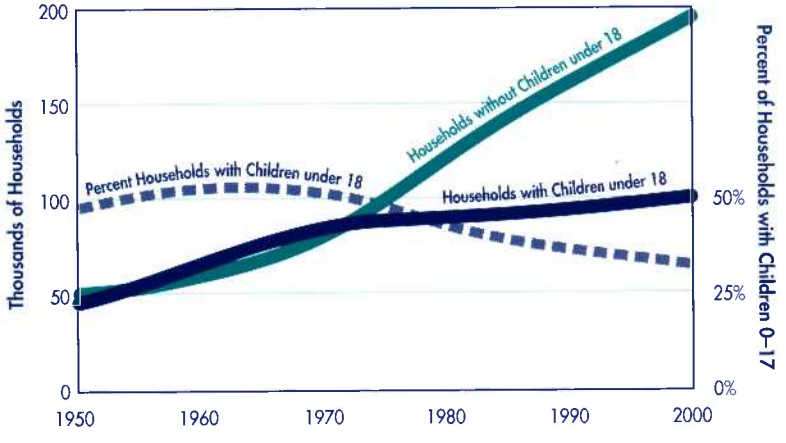
Notes: When necessary we have included technical or explanatory notes under the graphs or tables.

Counties and Cities: Where possible, data was delineated by counties and the city of Wilmington.

Pages are identified as KIDS COUNT (K) or FAMILIES COUNT (F).

As we quickly approach the year 2000, information from the 1990 U.S. Census becomes less reliable. However, it is helpful to provide this information to track trends.

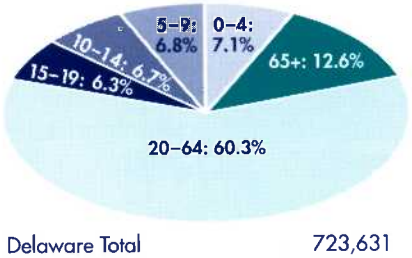
Number and Percent of Delaware Households with Children 0–17



Source: Center for Applied Demography and Survey Research

Population Estimate and Age Distribution

Delaware, 1996



Delaware Total	723,631
Total Children 0–19	195,181
Children 0–4	51,226
Children 5–9	49,294
Children 10–14	48,718
Children 15–19	45,943

Source: Population Estimates Program, Population Division, U.S. Census Bureau

One of the problems of providing accurate data is the lack of up-to-date information. For example, the source of child poverty facts in the United States is the U.S. Census Bureau. Census data are measured in two ways: once a decade (decennial) and by the Current Population Survey. Therefore, detailed information on child poverty can sometimes be unreliable due to age.

In a state with a small population such as Delaware, the standard sampling error is somewhat larger than in most states. For this reason, KIDS COUNT has portrayed the high school dropout rate in two ways: the sampling size which shows trends and the Department of Education's dropout numbers. There is a slight variation in those two graphs due to the size of the population.

Numbers, Rates, and Percentages

Each statistic tells us something different about children. The numbers represent real individuals. The rates and percentages also represent real individuals but have the advantage of allowing for comparisons between the United States and Delaware and between counties.

In this publication, indicators are presented as either raw numbers (25), percentages (25%), or rates (25 per 1,000 or 25 per 100,000). The formula for percents or rates is the number of events divided by the population at risk of the event (county, state, U.S.) and multiplied by 100 for percent or 1,000 or 100,000 for rates.

Caution should be exercised when attempting to draw conclusions from percents or rates which are based on small numbers. Delaware and its counties can show very large or very small percentages as a result of only a few events. KIDS COUNT encourages you to look at overall trends

A Caution About Drawing Conclusions

The key in the evaluation of statistics is to examine everything in context. The data challenges stereotypes, pushing us to look beyond the surface for the less obvious reasons for the numbers. Individual indicators, like the rest of life's concerns, do not exist in a vacuum and cannot be reduced to a set of the best and worst counties in our state.

Where county level data are presented, readers can gain a better understanding of the needs in particular segments of the state. Delaware rankings within the National KIDS COUNT Data Book can fluctuate from year to year. Therefore, it is important to look at the trends within the state and over a significant period of time. Hopefully the graphs will contribute to that picture.

In the future, we expect the data used to assess child well-being in Delaware will be more timely and will contain more complete information on the state's racial and ethnic communities than is currently available.

Overview

Delaware Compared to U.S. Average | Recent Trend in Delaware

Births to Teens

Number of births per 1,000 females ages 15–17

Five year average, 1992–96: Delaware 44.8, U.S. 36.6

Low Birth Weight Babies

Percentage of infants weighing less than 2,500 grams (5.5 lbs.) at live birth (includes very low birth weight)

Five year average, 1992–96: Delaware 8.0, U.S. 7.2

Infant Mortality

Number of deaths occurring in the first year of life per 1,000 live births

Five year average, 1992–96: Delaware 7.9, U.S. 8.0

Child Deaths

Number of deaths per 100,000 children 1–14 years old

Five year average, 1992–96: Delaware 23.3

Five year average, 1991–95: U.S. 29.1*

* U.S. data for 1992–96 was not available. 1991–95 data was used for comparison.

Teen Deaths by Accident, Homicide, and Suicide

Number of deaths per 100,000 teenagers 15–19 years old

Five year average, 1992–96: Delaware 47.5

Five year average, 1991–95: U.S. 68.0*

* U.S. data for 1992–96 was not available. 1991–95 data was used for comparison.

Delaware Compared to U.S. Average

Recent Trend in Delaware

Juvenile Violent Crime Arrest Rate

Number of arrests for violent crimes per 1,000 children 10–17; includes homicide, forcible rape, robbery, and aggravated assault

1996: Delaware 8.4, 1995*: U.S. 4.8

* U.S. data for 1996 was not available. 1995 data was used for comparison.

Teens Not Graduated and Not Enrolled

Percentage of youths 16–19 who are not in school and not high school graduates

Three year average, 1995–97: Delaware 8.4, U.S. 9.9

Teens Not Attending School and Not Working

Percentage of teenagers 16–19 who are not in school and not employed

Three year average, 1995–97: Delaware 9.3, U.S. 9.0

Children in Poverty

Percentage of children in poverty. In 1996 the poverty threshold for a one-parent, two-child family was $12,641. For a family of four with two children, the threshold was $15,911.

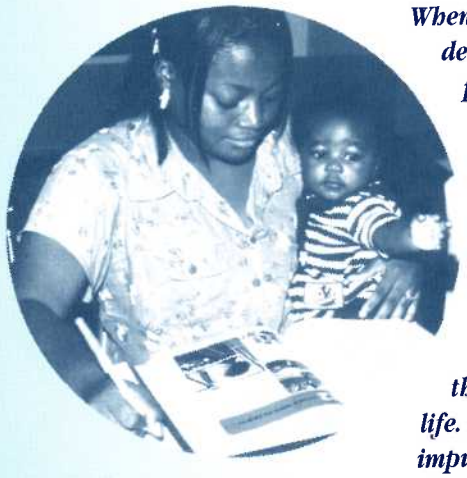
Three year average, 1995–97: Delaware 14.5, U.S. 21.6

Children in One-Parent Households

Percentage of children ages 0–17 living with one parent.

Three year average, 1995–97: Delaware 34.4, U.S. 30.5

Births to Teens 15–17



When an adolescent becomes a mother, the teen, her baby, and society all have to deal with the consequences. These consequences are often attributable to poverty and other adverse socioeconomic circumstances that frequently accompany early childbearing [1]. Teen mothers tend to be disadvantaged at the time of their child's birth. With the new demands of parenting, they are at risk of falling even further behind their more advantaged counterparts who will not become pregnant as teens. Teen mothers are more likely than other mothers to need additional financial support and to obtain less education [2].

Babies born to teens generally have a greater risk of health problems than those born to older women. Problems tend to follow these children throughout life. In preschool, they display higher levels of aggression and lower levels of impulse control. By adolescence, these children tend to have higher rates of grade failure and more delinquency. They become sexually active at an early age and are likely to become parents as teens themselves [3].

1 Males, M (1997). Women's health: adolescents. *Lancet, 349* (Supplement I), 13-16. Bacharach, C. A. and Carve, K. (1992). Outcomes of early childbearing: an appraisal of recent evidence. Summary of the National Institute of Child Health and Human Development conference, Betheseda, MD.

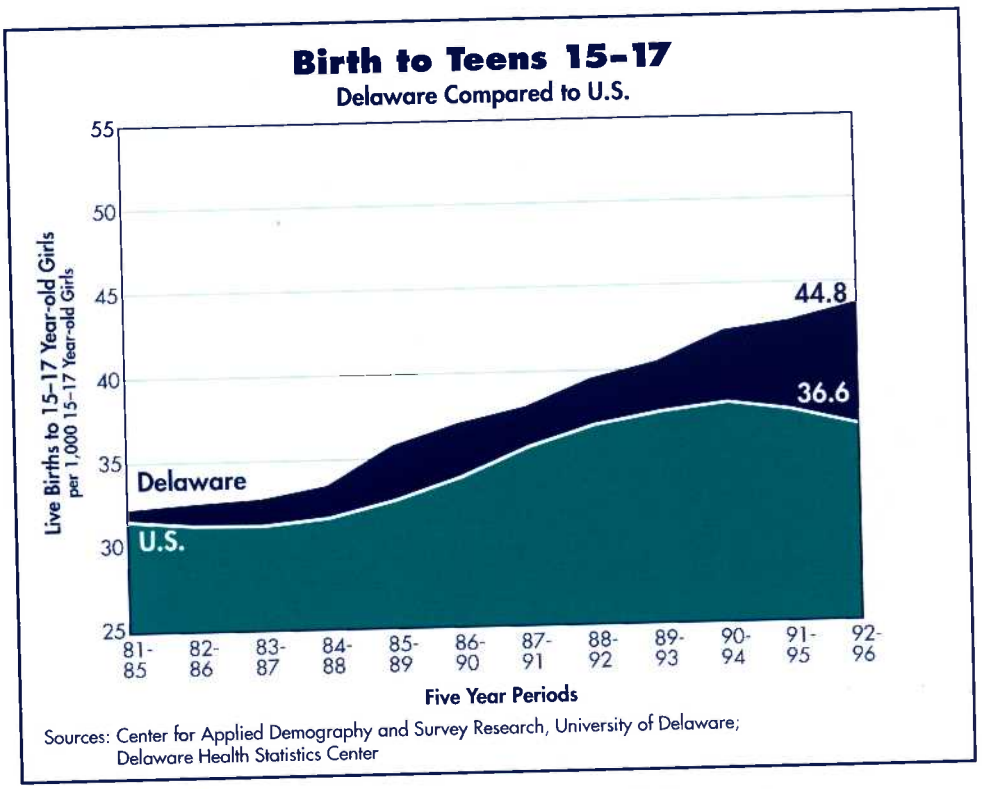
2 The Alan Guttmacher Institute. (1994). *Sex and America's Teenagers.* New York and Washington.

3 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998.* Washington D. C.

Definition:

Birth Rate– number of births per 1,000 females in the same group

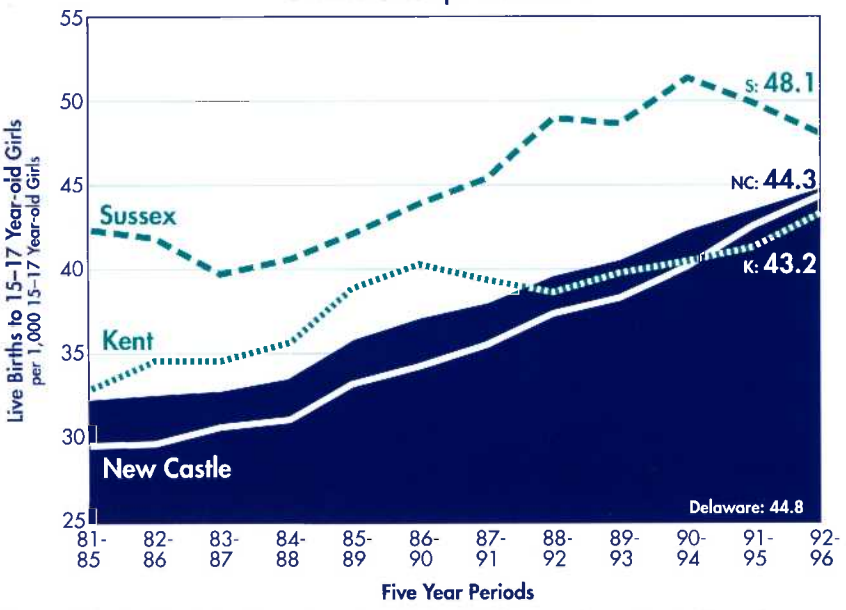
For more information see



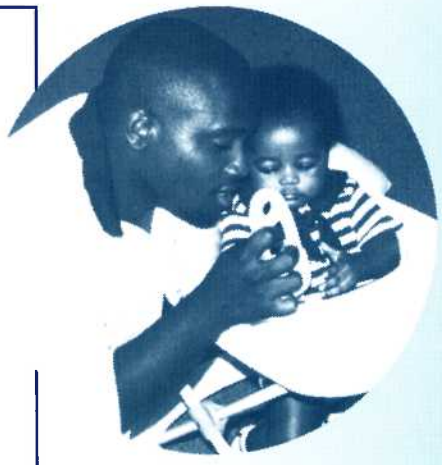
Sources: Center for Applied Demography and Survey Research, University of Delaware; Delaware Health Statistics Center

Birth to Teens 15-17

Delaware Compared to U.S.



Sources: Delaware Population Consortium; Center for Applied Demography and Survey Research, University of Delaware; Delaware Health Statistics Center



Did you know:

- the sons of teen mothers are **13%** more likely to **end up in prison**
- the daughters of teen mothers are **22%** more likely to become **teen mothers** themselves
- nearly **80%** of unmarried teen mothers end up **on welfare**
- **only 1/3** of teenage mothers receive a high school **diploma**
- a sexually active teen who does not use contraception has a **90% chance of pregnancy** within one year
- **one of every three girls has had sex by age 16**, one out of two by age 18; three of four boys have had sex by age 18

Communication is key

Almost one fourth of parents (24%) say the biggest barrier to effective communication about sex is that parents are not comfortable talking to their children. Only 17% of teens feel that is the biggest barrier.

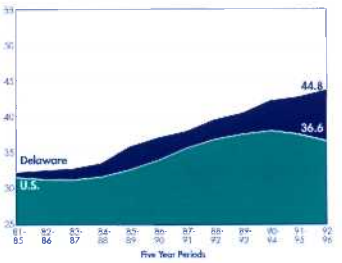
Nearly one in four (23%) teens said they want to hear more about sexually transmitted diseases, contraception, and pregnancy prevention from their parents.

Source: National Campaign to End Teenage Pregnancy, Available: HYPERLINK http://www.teenpregnancy.org

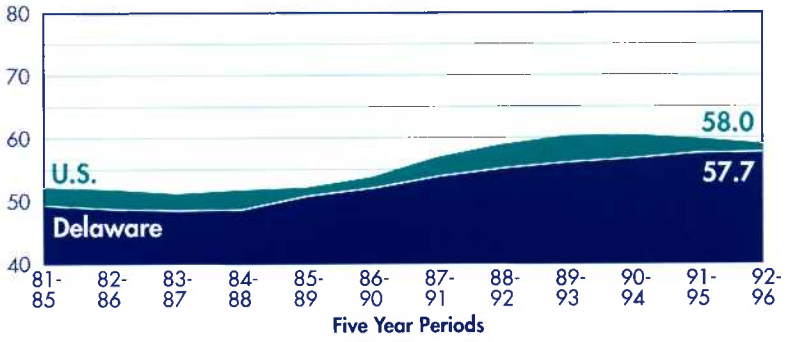
Births to Teens 15–19

While the birth rate for all Delaware teens 15–19 is slightly lower than the national rate, the birth rate for younger teens (ages 15–17) is considerably higher than the national average.

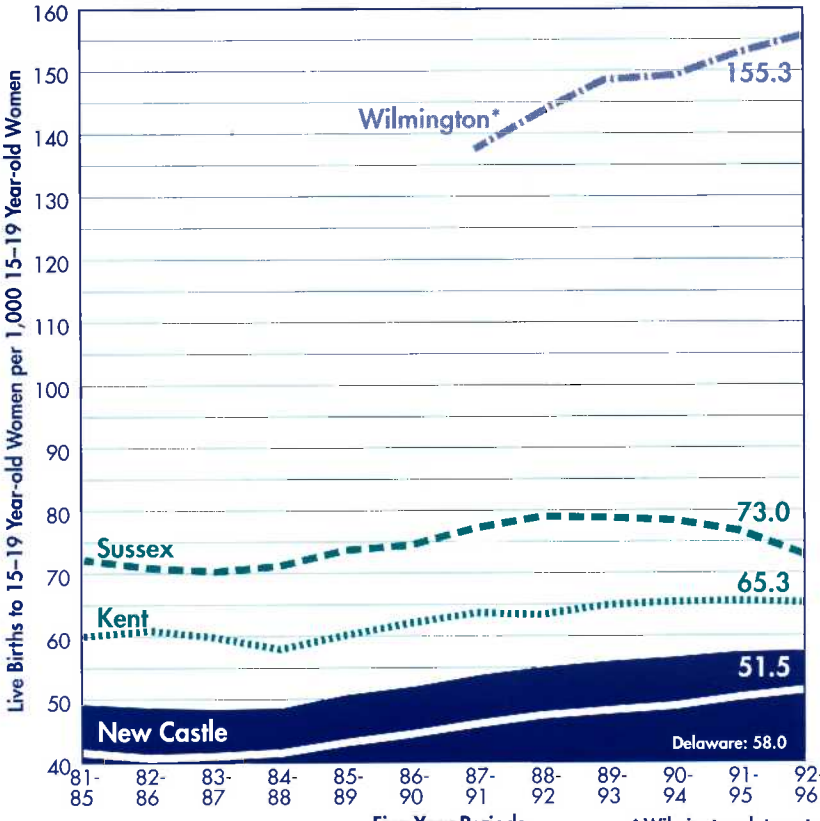
Births to Teens 15–17
as shown on page K-12



Births to Teens 15–19
Delaware Compared to U.S.



Births to Teens 15–19
Delaware, Counties and Wilmington

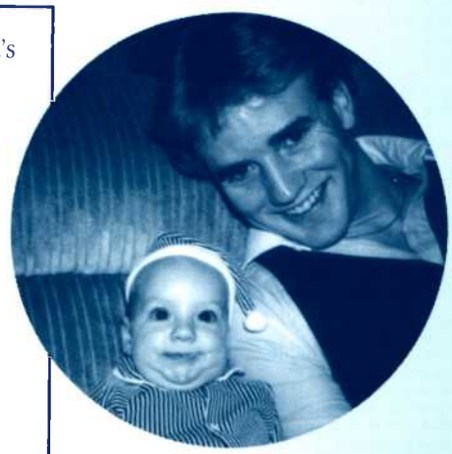


Source: Delaware Health Statistics Center

* Wilmington data not available before the 1987–1991 period

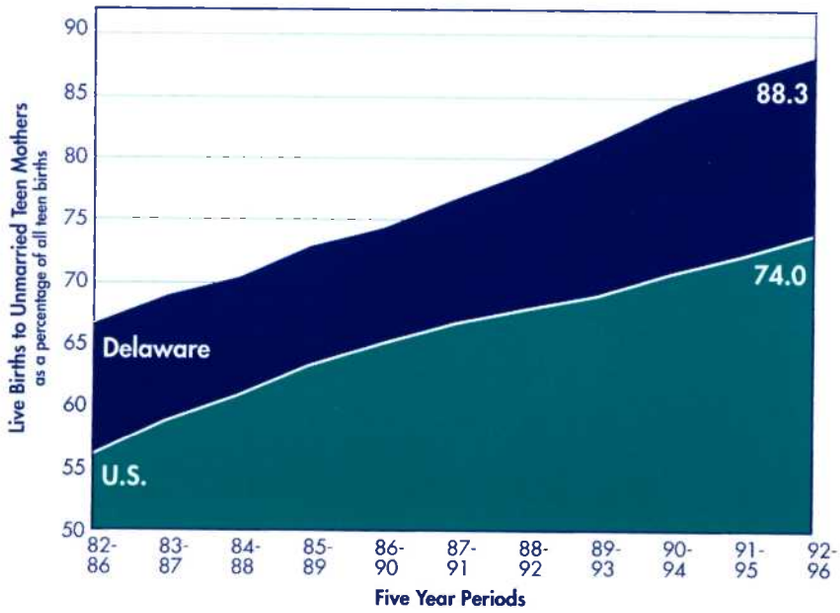
For more information see

Teen mothers in Kent and Sussex are more likely to be married at the time of the child's birth than their New Castle counterparts. However, the rate of births to unmarried teens throughout Delaware exceeds the national rate while the overall trend is a continued increase in the rate.



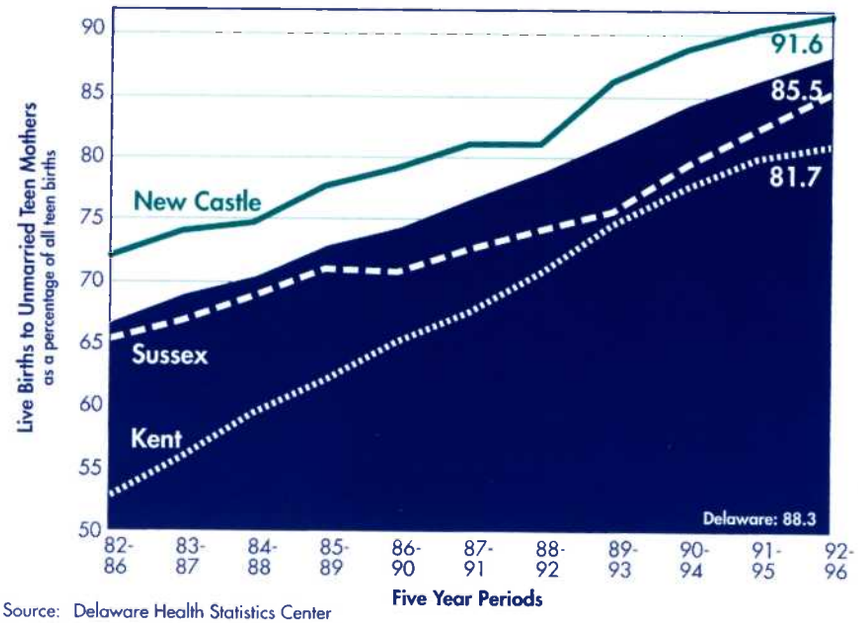
Births to Unmarried Teen Mothers

Delaware Compared to U.S.



Births to Unmarried Teen Mothers

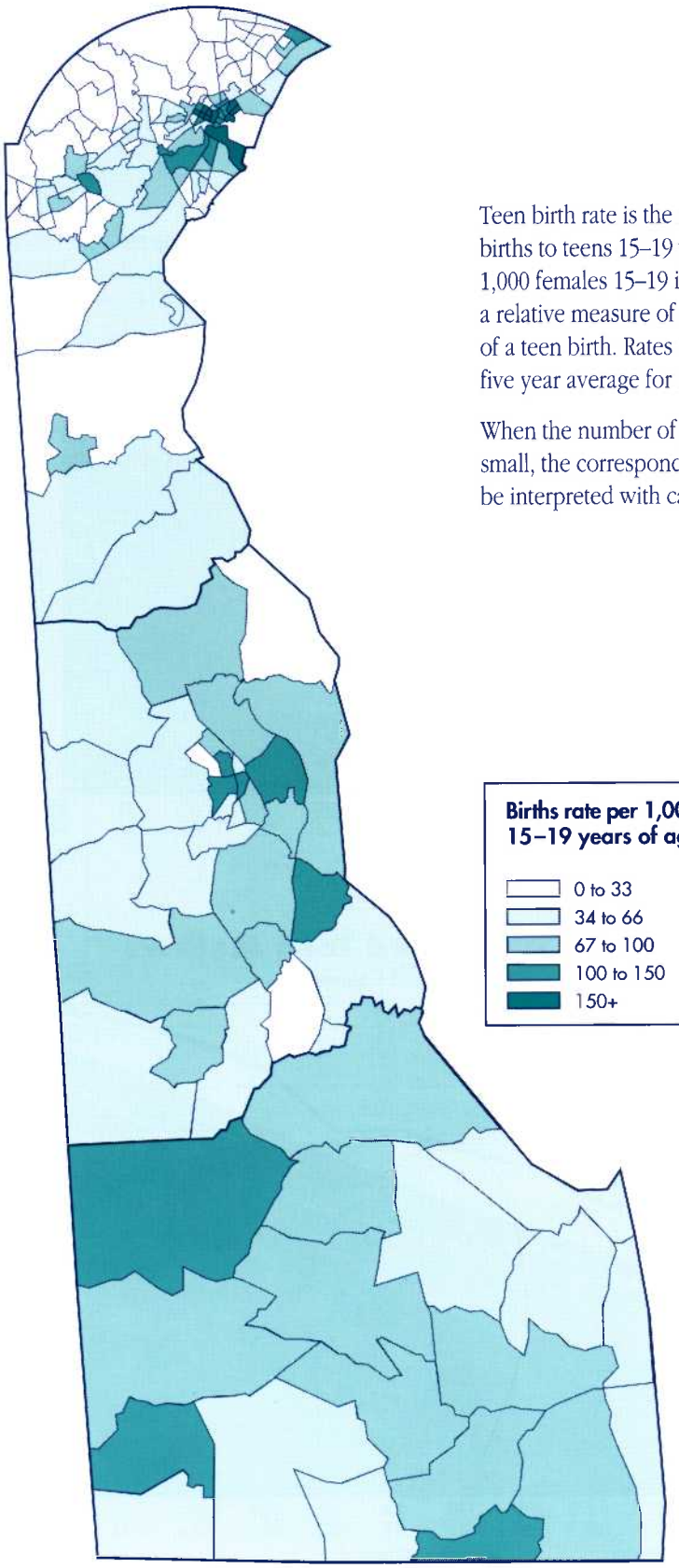
Delaware and Counties



Source: Delaware Health Statistics Center

Birth Rates for Girls 15–19

by Census Tract, Delaware 1991–1995



Teen birth rate is the number of births to teens 15–19 years of age per 1,000 females 15–19 in the tract. It is a relative measure of the likelihood of a teen birth. Rates are based on a five year average for 1991–1995.

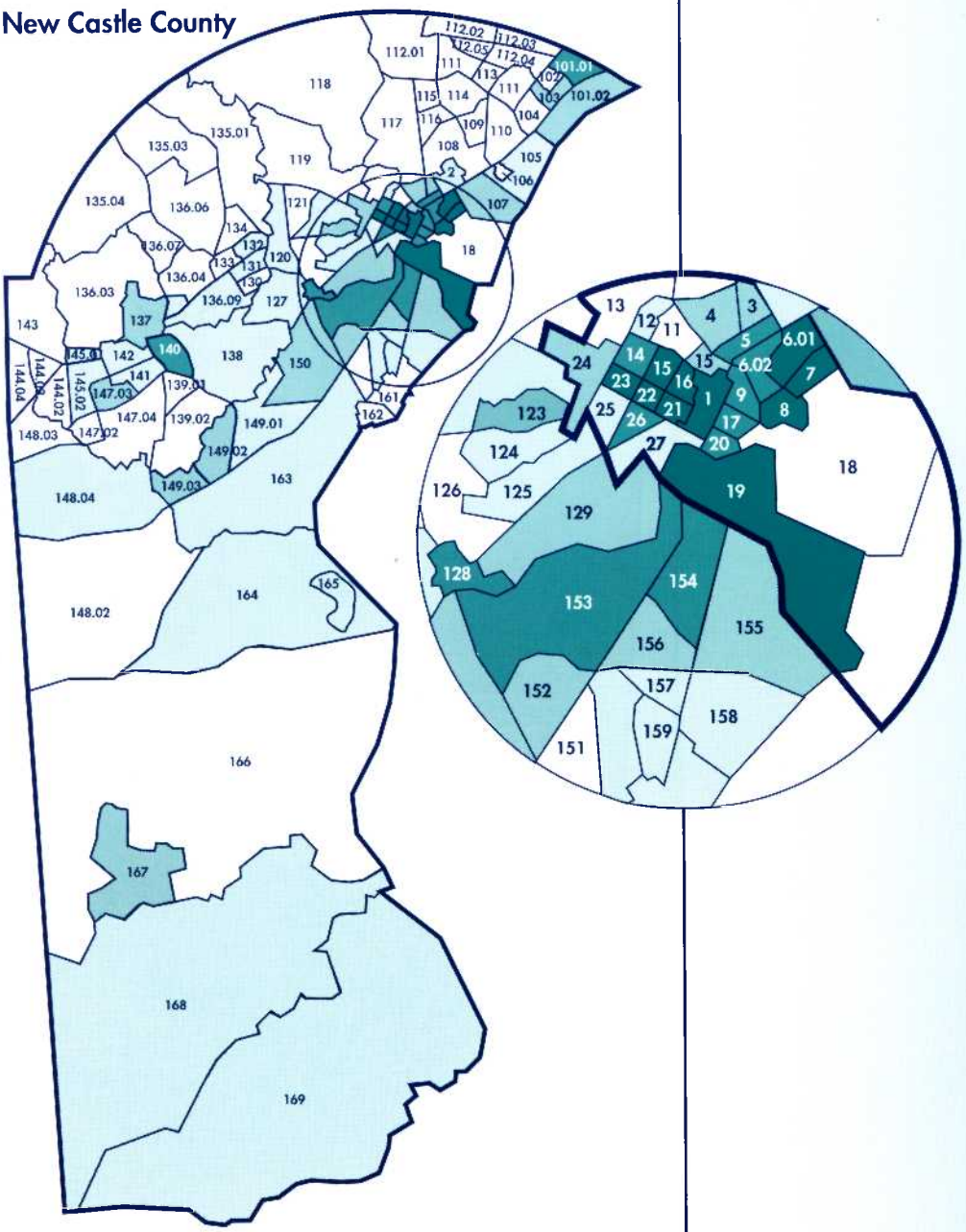
When the number of teen births is small, the corresponding rate should be interpreted with caution.

Source: Delaware Health Statistics Center

Birth Rates for Girls 15–19

by Census Tract, New Castle County

Census Tract	Rate/ 1,000	Number of Births
1	316.7	19
2	61.5	69
3	88.3	61
4	88.2	32
5	145.5	118
6.01	163.5	114
6.02	147.7	101
7	264.3	115
8	280.0	8
9	141.5	83
10	80.0	4
11	27.3	3
12	59.3	8
13	2.2	1
14	133.3	35
15	158.8	56
16	215.0	92
17	124.8	80
19	213.2	88
20	112.0	14
21	134.0	72
22	173.8	151
23	169.1	133
24	92.1	59
25	59.5	26
26	118.5	49
27	37.0	10
101.01	107.7	67
101.02	74.7	28
102	15.2	6
103	85.7	50
104	23.5	17
105	50.0	21
106	25.8	4
107	69.4	55
108	4.6	3
109	2.7	1
110	6.1	3
111	11.1	4
112.01	11.6	5
112.02	8.1	6
112.03	24.5	17
112.04	7.1	4
112.05	8.6	3
112.06	1.1	1
113	6.1	2
114	1.6	1
115	9.3	4
116	4.3	2
117	0.0	0
118	3.4	2
119	14.1	6
120	45.3	25
121	32.5	13
122	57.1	41
123	73.8	24
124	59.2	30
125	43.1	28
126	23.0	10
127	34.4	16
128	117.2	17
129	80.2	69
130	28.6	9
131	44.8	15
132	55.4	19
133	11.9	4
134	13.5	7
135.01	3.7	4
135.03	4.5	7



Tract	Rate	Births
135.04	5.6	8
136.03	17.9	21
136.04	28.6	15
136.06	3.1	5
136.07	26.7	16
136.08	50.0	13
136.09	59.4	38
137	72.0	56
138	38.6	33
139.01	31.8	27
139.02	26.1	29
140	102.9	70
141	51.8	44
142	36.8	7
143	6.1	6
144.02	12.8	6
144.03	8.4	4

Tract	Rate	Births
144.04	14.9	7
145.01	50.0	6
145.02	43.5	5
147.02	32.7	8
147.03	71.5	54
147.04	29.4	44
148.02	25.8	46
148.03	32.1	10
148.04	40.7	61
149.01	52.5	124
149.02	69.0	62
149.03	84.9	106
150	75.9	32
151	26.1	18
152	87.0	71
153	106.7	8
154	137.6	67

Tract	Rate	Births
155	78.0	49
156	86.8	48
157	45.0	9
158	63.5	33
159	46.4	16
160	57.5	43
161	32.6	14
162	31.9	16
163	58.0	98
164	53.2	21
165	56.8	23
166	25.0	31
167	70.1	49
168	35.2	30
169	46.5	24

Births rate per 1,000 females 15–19 years of age

- 0 to 33
- 34 to 66
- 67 to 100
- 100 to 150
- 150+

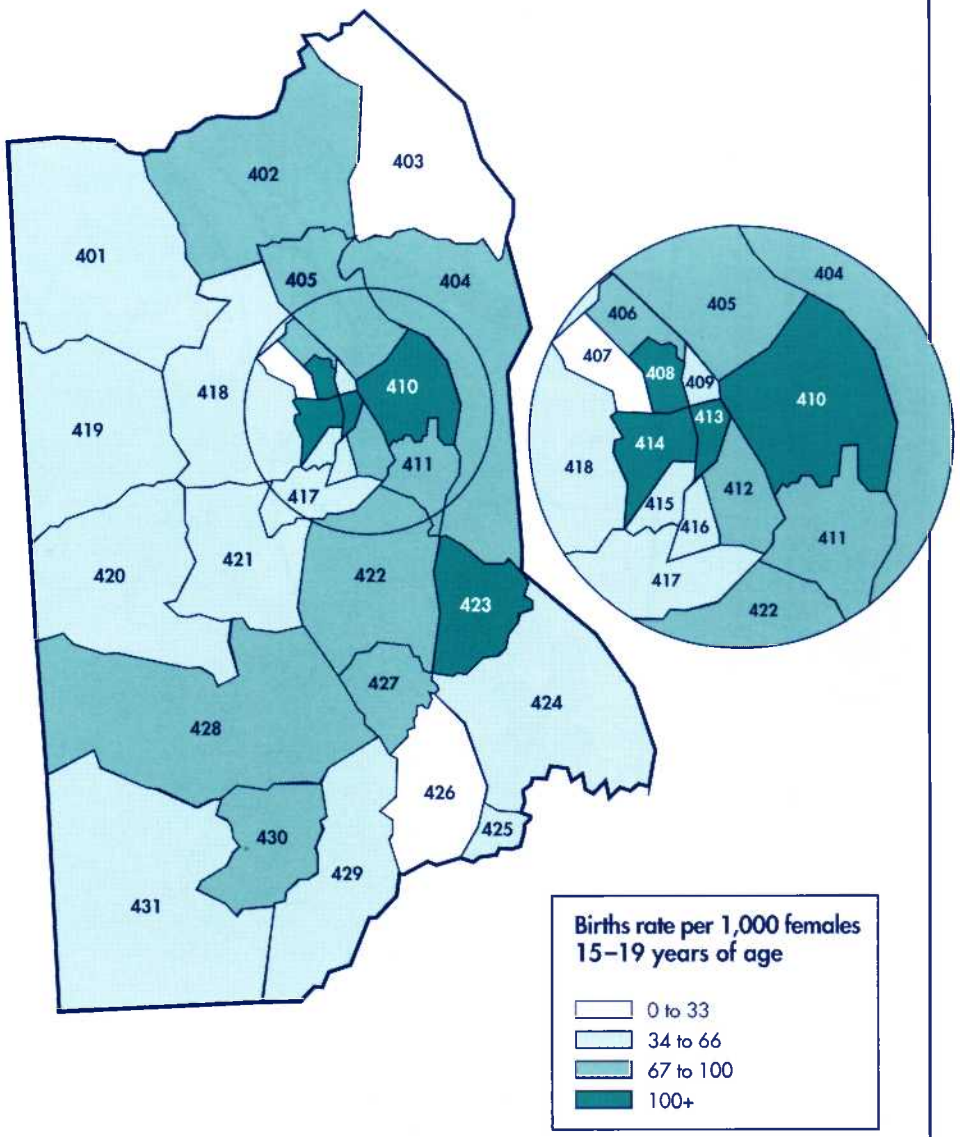
Teen birth rate is the number of births to teens 15–19 years of age per 1,000 females 15–19 in the tract.

Note: Any tract with 20 or less events should be interpreted with caution.

Source: Delaware Health Statistics Center

Birth Rates for Girls 15–19

by Census Tract, Kent County

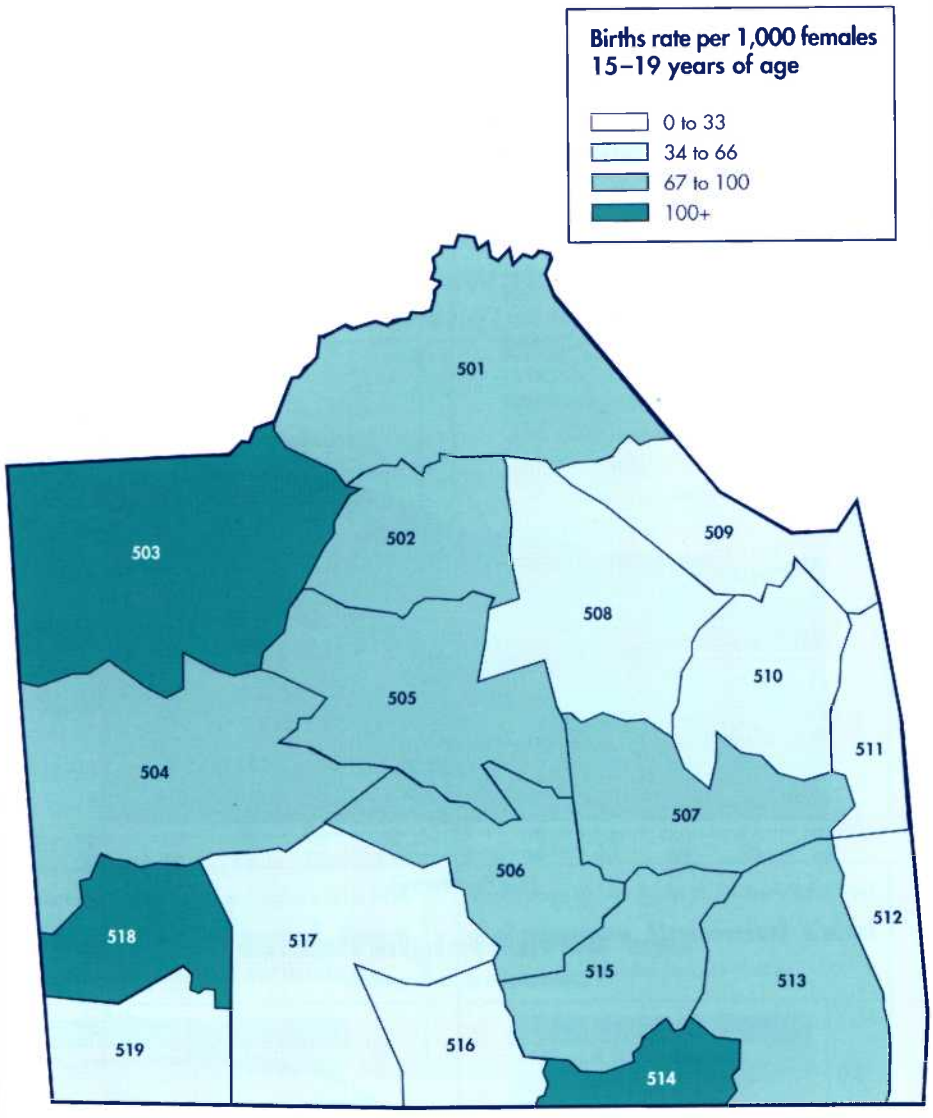


Census Tract	Rate/ 1,000	Number of Births	Census Tract	Rate/ 1,000	Number of Births	Census Tract	Rate/ 1,000	Number of Births
401	53.7	47	412	67.2	46	423	137.5	12
402	67.1	110	413	109.6	43	424	56.4	11
403	22.2	1	414	114.3	54	425	43.2	28
404	90.3	15	415	41.6	33	426	29.1	8
405	78.0	67	416	36.6	16	427	97.7	21
406	82.4	7	417	63.9	80	428	73.7	77
407	31.4	31	418	45.2	64	429	58.9	33
408	103.8	56	419	65.9	62	430	87.7	57
409	41.5	12	420	59.2	38	431	48.9	22
410	104.3	74	421	59.3	36			
411	80.3	53	422	73.4	136			

Teen birth rate is the number of births to teens 15–19 years of age per 1,000 females 15–19 in the tract.
Note: Any tract with 20 or less events should be interpreted with caution.
Source: Delaware Health Statistics Center

Birth Rates for Girls 15–19

by Census Tract, Sussex County



Census Tract	Rate/ 1,000	Number of Births	Census Tract	Rate/ 1,000	Number of Births
401	53.7	47	511	38.1	8
501	70.4	148	512	44.4	4
502	76.9	44	513	71.3	60
503	103.9	139	514	129.0	61
504	72.6	267	515	94.6	75
505	94.1	142	516	45.5	10
506	77.4	86	517	59.3	56
507	70.5	63	518	107.4	127
508	51.0	70	519	61.7	41
509	54.1	36			
510	60.4	66			

Teen birth rate is the number of births to teens 15–19 years of age per 1,000 females 15–19 in the tract.
Note: Any tract with 20 or less events should be interpreted with caution.
Source: Delaware Health Statistics Center

Low Birth Weight Babies

Low birth weight is defined as an infant being born at or below 2,500 grams (about 5.5 pounds). While low birth weight births account for only 4 to 5 percent of births among those of high socioeconomic status, 10 to 15 percent of the births to those in a lower socioeconomic status are born at low birth weight [1]. Risk factors associated with low birth weight include poor prenatal habits, in particular alcohol or tobacco use during pregnancy. Maternal age and mother's level of education are also correlated with low birth weight [2]. There also seems to be racial variation in low birth weight birth rates due to an unexplained higher rate of pre-term delivery in the African American population [3].

Definitions

Infancy – the period from birth to one year

Neonatal – the period from birth to 27 days

Low Birth Weight Babies – percentage of infants weighing less than 2,500 grams (5.5 lbs.) at birth (includes very low birth weight)

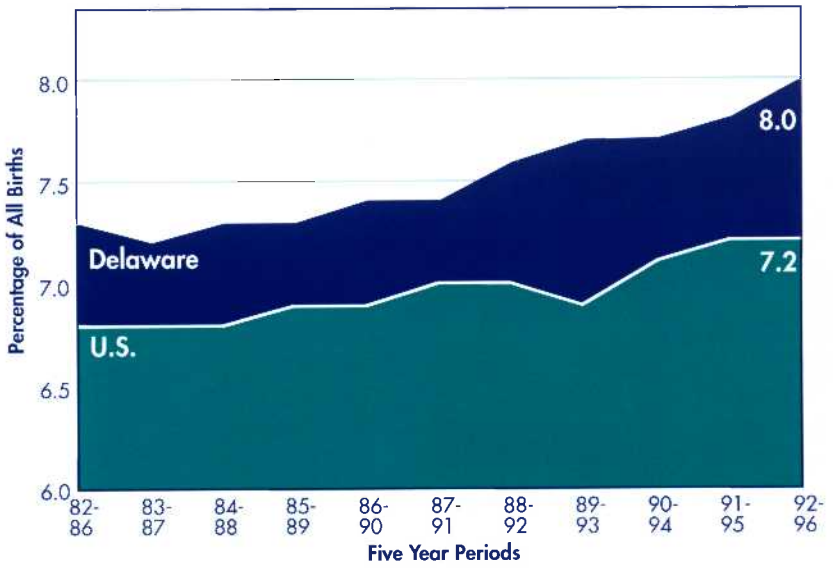
Very Low Birth Weight – less than 1,500 grams (3.3 lbs.)

Adequate Prenatal Care – frequency and quality as measured by the Kessner Index: The Kessner Index defines adequate prenatal care as (a) the first prenatal visit occurring during the first trimester of pregnancy and (b) periodic visits throughout pregnancy totaling nine or more prenatal visits by the 36th week of gestation. Inadequate care is defined as (a) the first prenatal visit occurring during the third trimester of pregnancy or (b) four or fewer prenatal visits by the 34th weeks of gestation. When the time of the initial visit and the total number of prenatal visits falls between these parameters, the adequacy of prenatal care is rated intermediate.

Birth Cohort – all children born within specified period of time

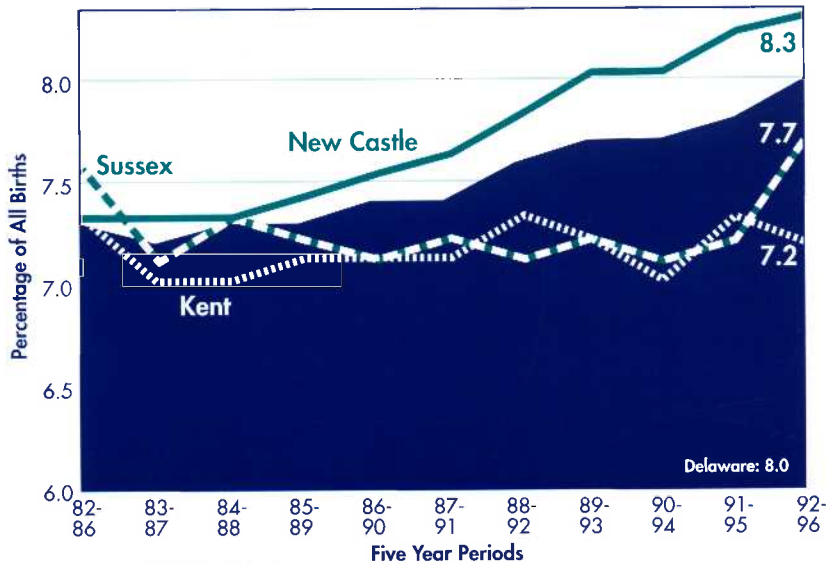
Low Birth Weight Babies

Delaware Compared to U.S.



Low Birth Weight Babies

Delaware and Counties



Source: Delaware Health Statistics Center

Low birth rate is a reliable predictor of infant mortality. It is associated with prolonged hospitalizations and persistent health problems. Children born at a low birth weight are at risk for developmental delays and disabilities. Many also have major birth defects.

1 Childhood diseases and disorders: disorders present at birth: prematurely and low birth weight. *Britannia Online*. Available <http://www.eb.com:180/cgi-bin?DocF=macro/5001/23/6.html>.

2 Abel, M. H. (1997, December). Low birth weight and interactions between traditional risk factors. *Journal of Genetic Psychology, 158*(4), 443-456.

3 Paneth, N. (1995, Spring). The Problem of low birthweight. *The Future of Children: Low Birthweight, 5*(1).

For more information see

Infant Deaths by Birth Weight of Infant p. K-23

Health problems in low-income children p. K-35

Tables 9–17 p. K-62–67

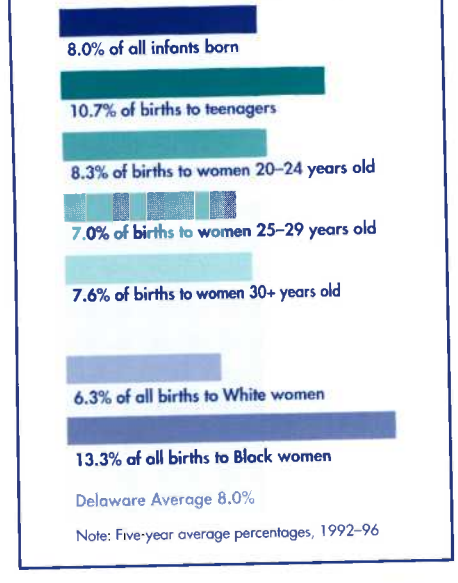
Tables 20–21 p. K-68–69

In the FAMILIES COUNT Section:

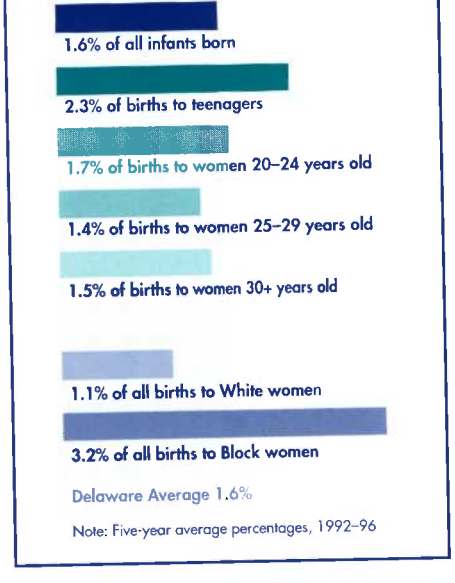
Prenatal Care p. F-10

Low Birth Weight Babies p. F-12

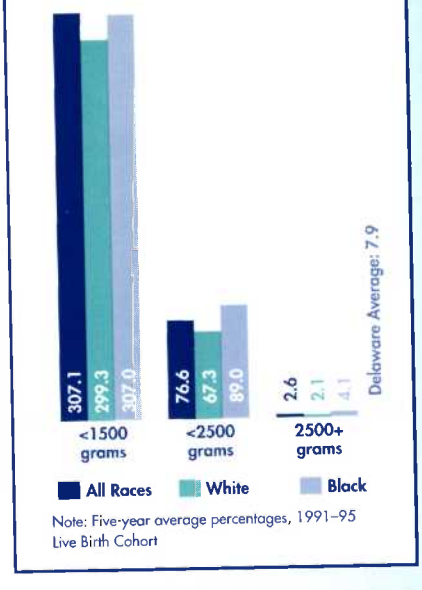
Percentage of Babies with
Low Birth Weight
(weight less than 2500 grams)
by Age and Race of Mother



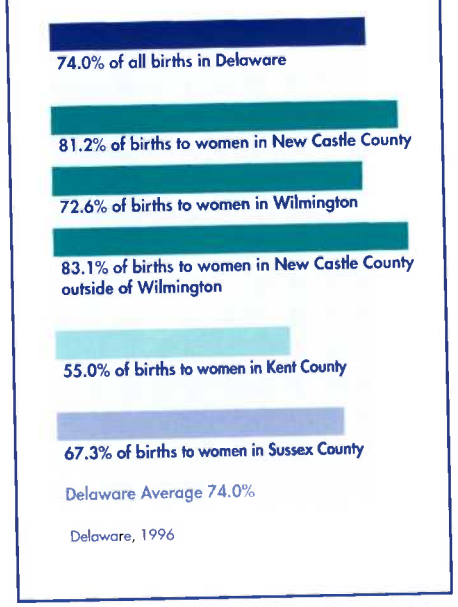
Percentage of Babies with
Very Low Birth Weight
(weight less than 1500 grams)
by Age and Race of Mother



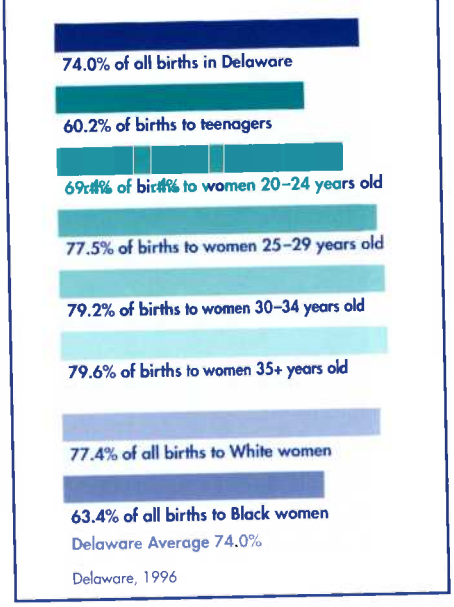
Infant Mortality
per 1,000 Live Births by Birth Weight of Infant and Race of Mother



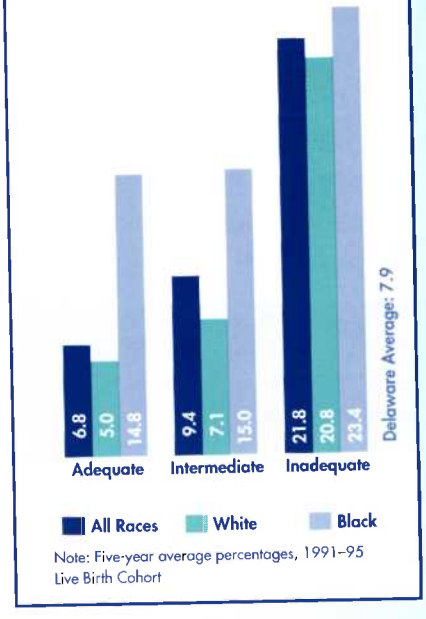
Percentage of Live Births to Mothers Who Had
Adequate Prenatal Care
by Delaware, Counties, and Wilmington



Percentage of Live Births to Mothers Who Had
Adequate Prenatal Care
by Age and Race of Mother

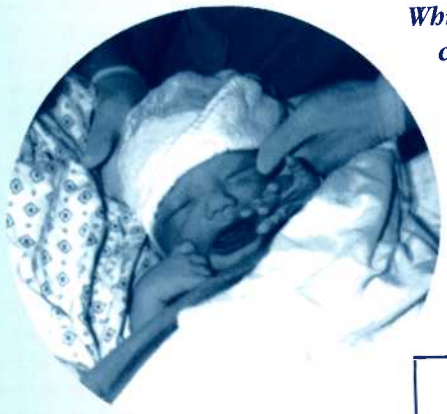


Infant Mortality
by Adequacy of Prenatal Care and Race of Mother



Source for six charts above: Delaware Health Statistics Center

Infant Mortality



While the infant mortality rate in the United States (and in Delaware) has continued to decline, the U.S. ranks 21st among industrialized nations in infant mortality rates[1]. The infant mortality rate measures the death of infants before their first birthday. There are conditions that increase risk of infant mortality. These include maternal age (less than 19 or over 40), timing of pregnancies (leaving less than two years between births), poor maternal health or nutrition, race, and inadequate prenatal care[2]. Infant mortality rates tend to be related to social and economic conditions in a community. Less advantaged communities including those with poor

Definition:

Infant Mortality Rate – number of deaths occurring in the first year of life per 1,000 live births

Birth Cohort – all children born within specified period of time. An infant death in the cohort means that a child born during that period died with the first year after birth.

Birth Interval– the time period between the current live birth and the previous live birth to the same mother.

For more information see

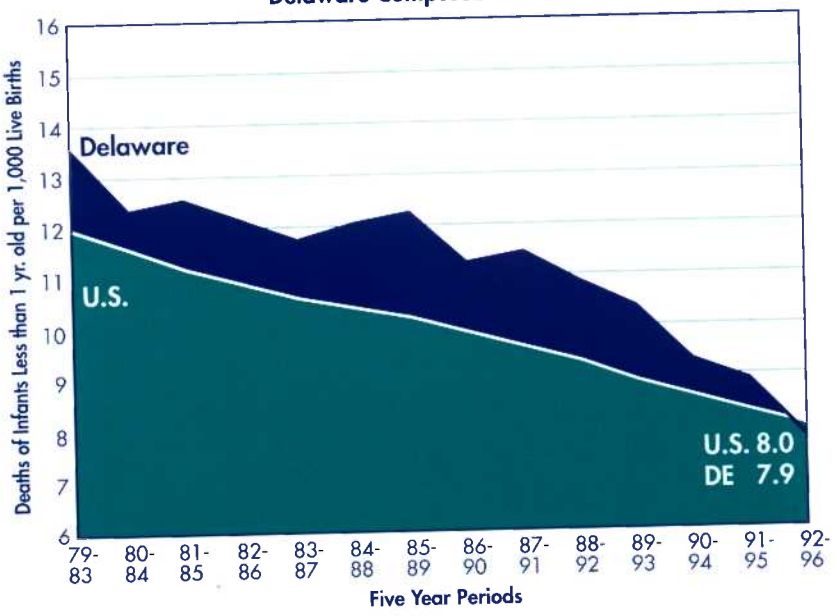
Low Birth Weight Babies	K-20
Child Deaths	p. K-24
Teen Deaths	p. K-26
Health problems in low-income children	p. K-35
Child Abuse and Neglect	p. K-48
Tables 18–21	p. K-67–70

In the FAMILIES COUNT Section:

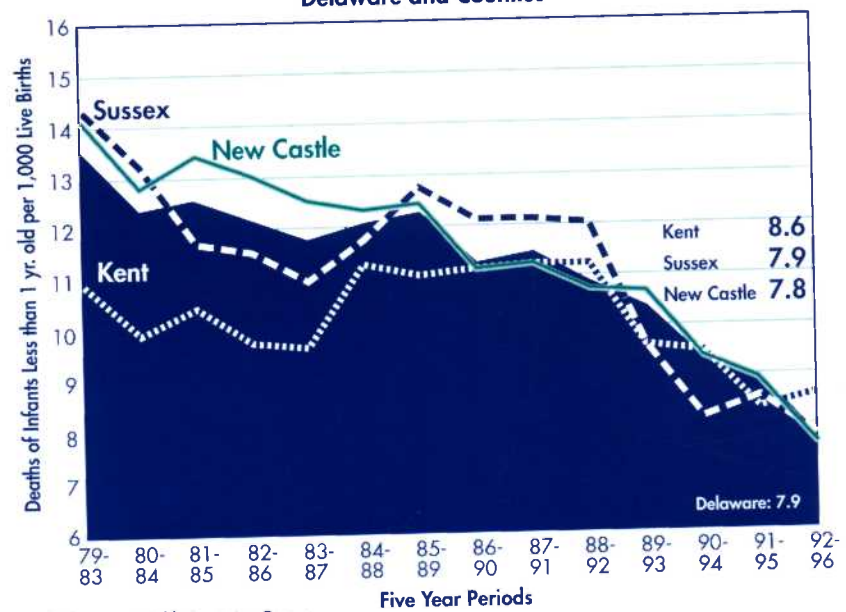
Prenatal Care	F-10
Low Birth Weight Babies	F-12
Infant Mortality	F-14

Infant Mortality

Delaware Compared to U.S.



Delaware and Counties



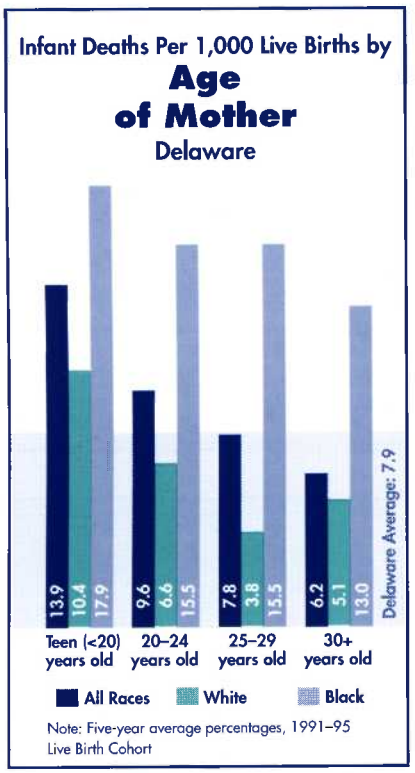
Source: Delaware Health Statistics Center

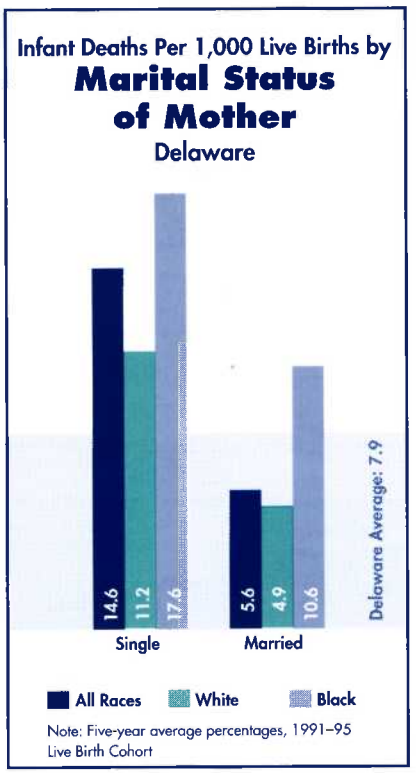
housing, persistent poverty, and high unemployment rates tend to have higher infant mortality rates than communities without such problems[3].

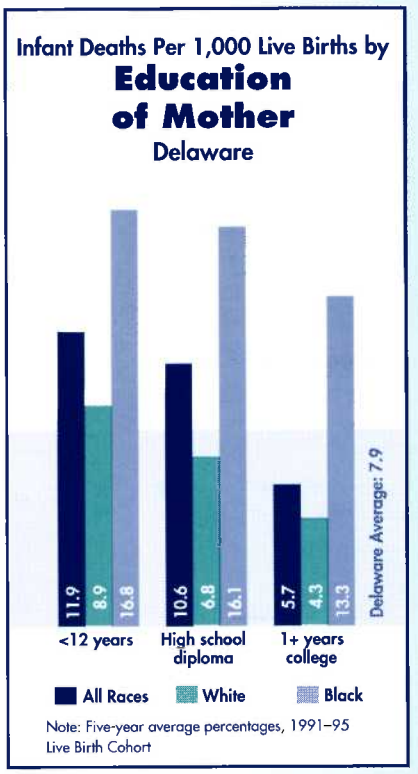
1 Infant mortality: the bad news... and the good. (1997, April). *Consultant, 37*(4), 1092.

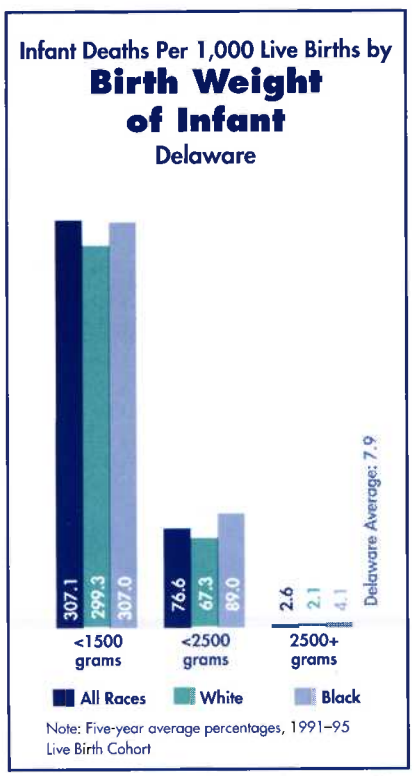
2 Infant mortality rate (1996). *1996 KIDS COUNT Data Book on Louisiana's Children.*

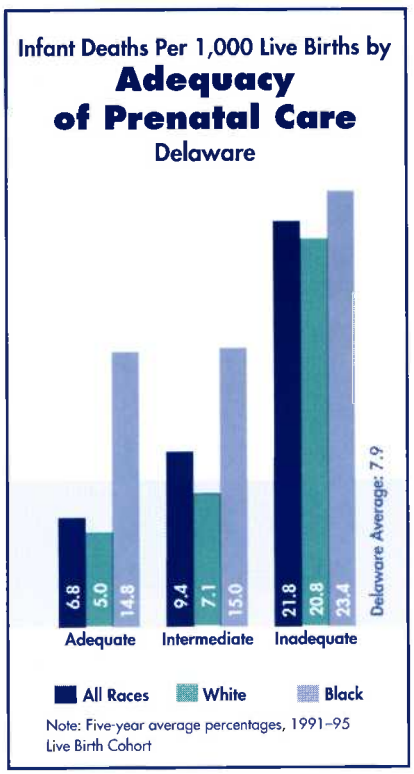
3 Infant mortality: significance. (1997). *1997 Rhode Island KIDS COUNT Factbook.*

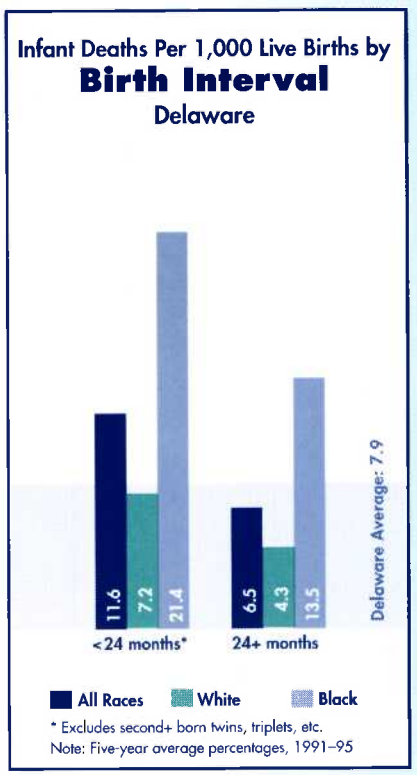












Source for six charts above: Delaware Health Statistics Center

Child Deaths *Children 1–14 Years of Age*

Child death rate is defined as the number of deaths per 100,000 children divided by age groups: 1 to 4 and 5 to 14. The Child Death Rate reflects risks that are fatal to children including poverty, lack of education, inadequate prenatal care, lack of health insurance, low birth weight, substandard living conditions, substance abuse, child maltreatment, and lack of adult supervision[1]. While it is estimated that 90% of unintentional injuries can be prevented, unintentional injuries remain the leading cause of death for children 1-4[2]. Injuries that do not result in death may leave children disabled, result in time lost from school, or decrease the child's ability to participate in activities[3].

1 Children's Safety Network. (1994). *Child and Adolescent Fatal Injury Data Book* Maternal and Child Health Bureau, U.S. Department of Health and Human Services: Washington, D. C.

2 National Safe Kids Campaign. (1996). *Childhood Injury Fact Sheet.* Washington, D. C.

3 Lewit, E. M. and Baker, L. S. (1995, Spring). Unintentional injuries. *The Future of Children, 5*(1).

Definition:

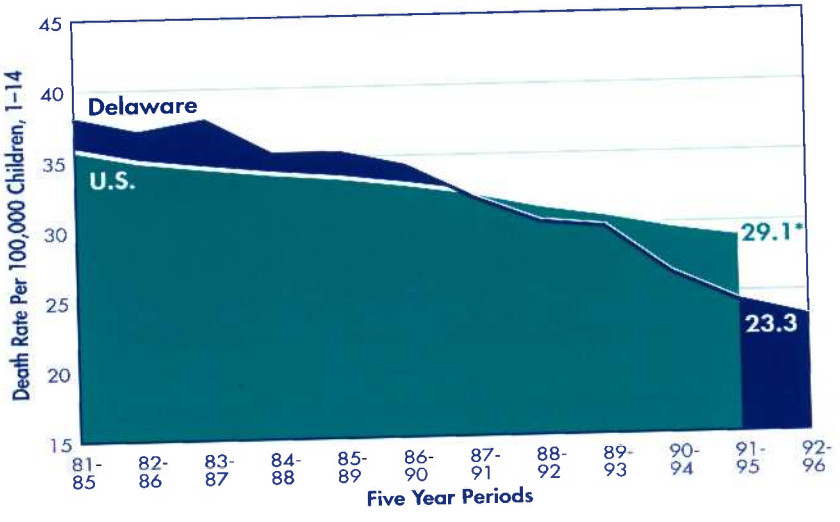
Child Death Rate – number of deaths per 100,000 children 1–14 years old

Unintentional Injuries – accidents, including motor vehicle crashes

For more information see

Child Deaths

Delaware Compared to U.S.



*** U.S. data for 1992–1996 was not available**

Sources: Delaware Health Statistics Center, National Center for Health Statistics

Number of Children 0–14 Who Died in 1996

in Delaware by County and Age

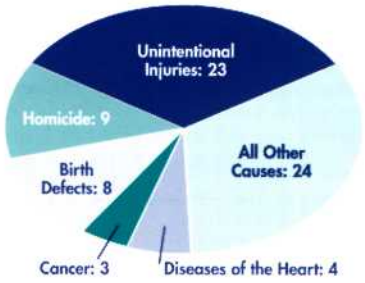
	Under 1	1–4	5–9	10–14
Delaware	77	10	8	9
New Castle Co.	48	2	6	3
Wilmington*	19	0	4	0
Kent Co.	17	2	1	1
Sussex Co.	12	6	1	5

* Wilmington data included in New Castle County total

Source: Delaware Health Statistics Center

Causes of Death of Children 1–4

Delaware, 1992–1996



Total Number of Deaths in five-year period: 71 Children

Source: Delaware Health Statistics Center

Causes of Death of Children 5–14

Delaware, 1992–1996

Total Number of Deaths in five-year period: 88 Children

Source: Delaware Health Statistics Center

Did you know:

- The primary cause of death for children of all ages in the United States is **unintentional injury**—which is often preventable [1].
- **Motor vehicle crashes** are the single largest cause of injury death for American children between ages 1 and 9. Following motor vehicle crashes, **fires** and related burns and **drowning** are the leading causes of unintentional injury deaths among American children. The death rates from fire and drowning among children ages 1–4 are approximately three times the rate among children ages 5–9.
- The rate of child deaths from **homicide** nearly tripled between 1960 and 1991. Homicide is now the fourth leading cause of death among children ages 1–9 [2].
- According to a 1990 estimate, approximately 3,600 children die each year. 20,000 become permanently disabled, 350,000 are hospitalized, and 15 million visit the emergency room because of **unintentional injuries** [3].

Sources:

1 Child Health USA '93. U.S. Department of Health and Human Service, Maternal and Child Health Bureau, 1993

2 Ibid.

3 The David and Lucile Packard Foundation. (1995, Spring). The Future of Children, Center for the Future of Children, 5 (1).

Teen Deaths by Accident, Homicide, and Suicide

Research shows that poverty, the increased availability of handguns, and the rise in gang activity are all risk factors associated with teen violent death[1]. Homicide and violence generally indicate delinquency, hostility, and anger and can be an indicator of community safety. Suicide is an indicator of stress, mental health, community support, and family support[2]. Compared with younger children, teens have a much higher rate of death from motor vehicle crashes and firearm related injuries[3].

1 Children's Safety Network. (1994). *Firearm facts: information on gun violence and its prevention.* Maternal and Child Health Bureau, U.S. Department of Health and Human Services. Washington, D. C.

2 Pennsylvania KIDS COUNT Partnership. (1995). *The State of the Child in Pennsylvania.*

3 Fingerhut, L. A., Annest, J. L., Baker, S. P., Kochanek, K. D., and McLaughlin, E. (1996). Injury mortality among children and teenagers in the United States, 1993. *Injury Prevention.*

Definition:

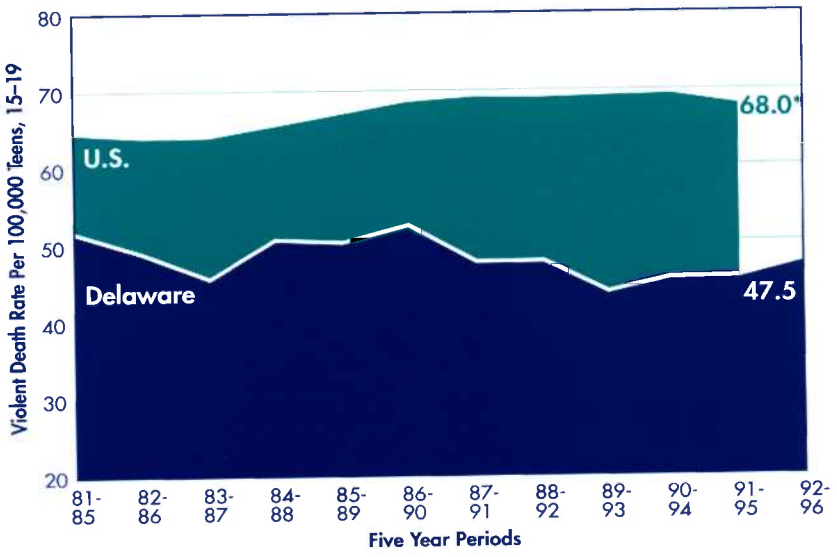
Teen Deaths by Accident, Homicide, and Suicide – number of deaths per 100,000 teenagers 15-19 years old

Unintentional Injuries – accidents, including motor vehicle crashes

For more information see

Teen Deaths by Accident, Homicide, and Suicide

Delaware Compared to U.S.



* U.S. data for 1992–1996 was not available

Sources: Delaware Health Statistics Center, National Center for Health Statistics

Deaths by Accident, Homicide, and Suicide of Youth 15–19 in 1996

in Delaware by Cause

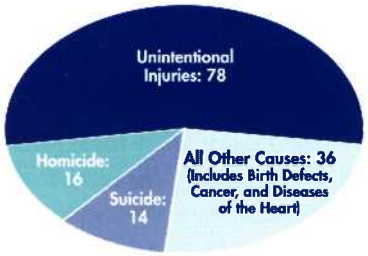
Homicide	4 males and 1 female
Suicide	3 males and 0 females
Motor Vehicle Crashes	7 males and 3 females
Other Unintentional Injuries	1 male and 1 female

Total Number of Deaths: 20 Teens

Source: Delaware Health Statistics Center

Causes of Death of Teens 15–19

Delaware, 1992–1996



Total Number of Deaths: 132 Teens

Source: Delaware Health Statistics Center

Did you know:

In 1996, 10 of the 12 deaths for youths ages 15–19 due to unintentional injuries were from **motor vehicle crashes**. Delaware has recently passed legislation aimed at preventing additional deaths. Delaware's new driving restrictions for teens to receive licenses follow.

After passing driver's education, passing the written test, and practicing with a learner's permit, teens can apply for Level 1 permit.

Level 1 A Level 1 permit requires 6 months of supervised driving.

This driving is permitted only between the hours of 5:00 A.M. and 10:00 P.M.

The person supervising must be a parent or legal guardian.

No other passengers are allowed in the car.

After 6 months, the time restriction is lifted. However, supervision is still required.

Level 2 After 12 months of Level 1 experience with no violations, a driver may apply for a Level 2 permit.

Now, the driver may drive unsupervised to and from work between the hours of 5:00 AM and 10:00 PM.

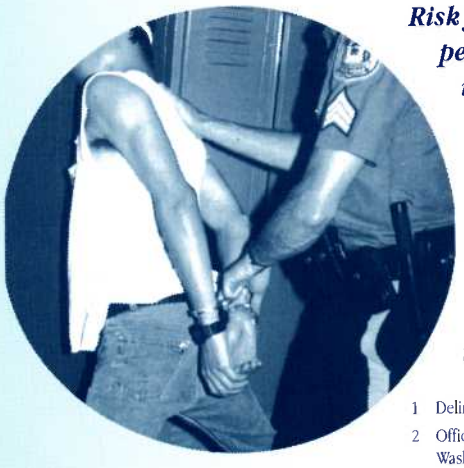
The driver may drive under supervision at any time and can carry passengers while under supervision.

Level 3 After 6 months of Level 2 with no violations, a driver can apply for Level 3.

Level 3 allows drivers unsupervised driving at any time.

License A driver may apply for a license at age 18 with 3 months of driving at Level 3 violation free.

Juvenile Violent Crime Arrests



Risk factors for juvenile violent crime and delinquency include poor school performance and limited job opportunities [1]. Poverty, family violence, and inadequate supervision are also factors that increase risk [2]. The general public adds media's influence to this list citing: too much sex and violence in the movies, too much sex and violence on TV, too much emphasis on sex in advertising, and rock music lyrics that glorify sex and violence [3].

Youth ages 12–19 are much more likely to be involved in crime as victims than any other age group. Teens are the victims of three in ten violent crimes and one in four thefts. They are also the least likely group to report the crimes [3].

1 Delinquency. *Britannia Online.* Available <http://www.eb.com:180/cgi-bin/g?DocF=micro/164/30.html>.

2 Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. (1995). *Juvenile Offenders and Victims, A National Report.* Washington, D. C.

3 Indiana Youth Institute, KIDS COUNT in Indiana. (1994). *Kids, Crime, ad Court: The Juvenile Justice System in Indiana.*

Definition:

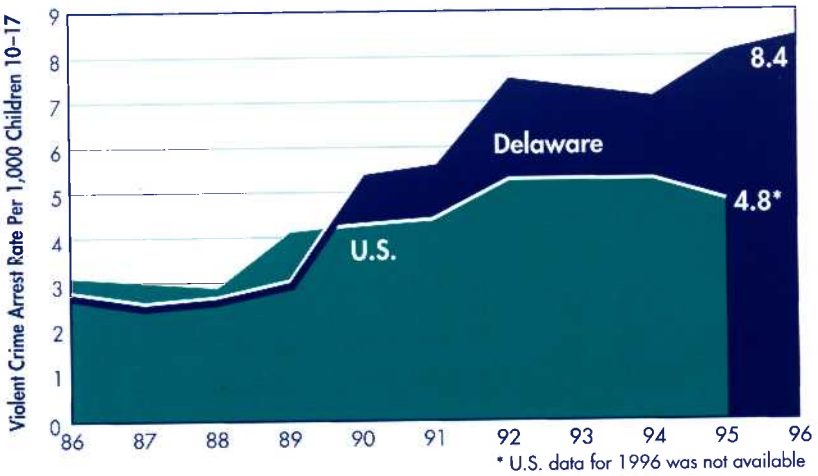
Juvenile Violent Crime Arrests – number of arrests for violent crimes per 1,000 children 10-17; includes homicide, forcible rape, robbery, and aggravated assault

For more information see

Teen Births, Did You Know	p. K-13
Teen Deaths	p. K-26
Tables 25–37	p. K-72–77
In the FAMILIES COUNT Section:	
Teen Deaths	p. F-23
Juvenile Delinquents in Out-of-Home Care	p. F-44
Juvenile Violent Crime	p. F-49
Adult Violent Crime	p. F-50
Adults on Probation or Parole	p. F-51

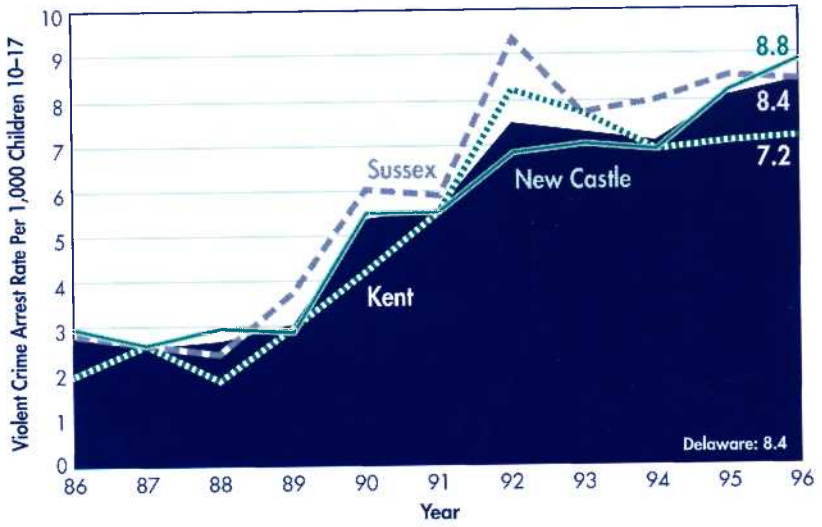
Juvenile Violent Crime Arrests

Delaware Compared to U.S.



* U.S. data for 1996 was not available

Delaware and Counties



Source: Statistical Analysis Center

Juvenile Victims and Their Perpetrators

Older rather than younger children are more likely to be victims of crime. At the low end of involvement, 5.7% of the incidents involve newborns to two year olds; at the high end of involvement, 41.3% of the incidents involve 15 to 17 year olds. Although very young children are less likely to be victims of crime, the raw numbers are still eye-opening when it is realized that for the crimes studied in one year there were 198 crime victims in Delaware between newborn and two years old, and 450 total crime victims 5 years old and less.

Gender involvement varies significantly by type of crime. Males are more likely to victimize children in crimes of sexual assault and robbery, while women are more likely to victimize children in crimes related to the welfare of the child, harassment and misdemeanor assault.

Source: Statistical Analysis Center, Attorney General's Task Force on Child Victims. (1997, October). *Juvenile Victims and Their Perpetrators.*

Victims and Perpetrators

Percent of Victims and Percent of Perpetrators by Crime Type and Gender

	Victims		Perpetrators	
	Male	Female	Male	Female
Homicide	84.6	15.4	84.6	15.4
Robbery	82.7	17.3	94.9	5.1
Theft	76.6	23.4	88.0	12.0
Felony Assault	71.3	28.7	80.7	19.3
Misdemeanor Assault	53.8	46.2	75.0	25.0
Welfare	52.8	47.2	49.0	51.0
Kidnapping	33.3	66.7	83.3	16.7
Harassment	27.0	73.0	63.5	36.5
Felony Sexual Assault	15.3	84.7	97.4	2.6
Misdemeanor Sexual Assault	13.6	86.4	94.4	5.6

Source: Statistical Analysis Center, Attorney General's Task Force on Child Victims. (1997, October). *Juvenile V ictims and Their Perpetrators.*

Student Violence and Possession

Delaware Code, Title 14 §4112, signed in July 1993, required that evidence of certain incidents of student conduct occurring in Delaware schools be reported to the Secretary of Education and to the Youth Division of the Delaware State Police. The State Board of Education expanded the reporting requirements of Title 14 to include evidence of other incidents involving school children such as reckless endangering, unlawful sexual conduct, or robbery.

In 28% (524) of the incidents, police charges were filed. In 235 of the incidents, possession and or concealment of dangerous instruments were involved. Possession of unlawful controlled substances accounted for an additional 273 incidents.

High School Dropouts

Children who receive a quality education are more likely to grow into capable, self-sufficient adults who are contributing members of society. Education in this ever-changing world is critical to a young person's success in the work force [1]. College graduates today earn twice the wages of high school graduates and nearly triple the wages of a high school dropout. Those youth who do dropout have not gained skills and knowledge essential for future success [2]. They are likely to live in poverty as the jobs they are likely to hold have incomes which go down over time in comparison to inflation [3].

Early warning signs for a student likely to drop out include:

- *missing or cutting class frequently*
- *excessive lateness to class*
- *inability to read at grade level*
- *poor grades*
- *being put on in-school suspension, suspension, or probation*
- *arrests*
- *substance abuse problems*
- *teen pregnancies or*
- *spending time in juvenile homes or shelters [4].*

1 High school graduation rate. significance. (1997). *1997 Rhode Island KIDS COUNT.*

2 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998.* Washington D. C.

3 Remarks by President Clinton to the Delaware State Legislature. (1998, May). Dover, DE: Senate Chambers.

4 Schwartz, W. School dropouts: new information about an old problem. *ERIC Clearinghouse on Urban Education Teacher's College,* Columbia University. Available <http://www.handsnet.org>.

Definition:

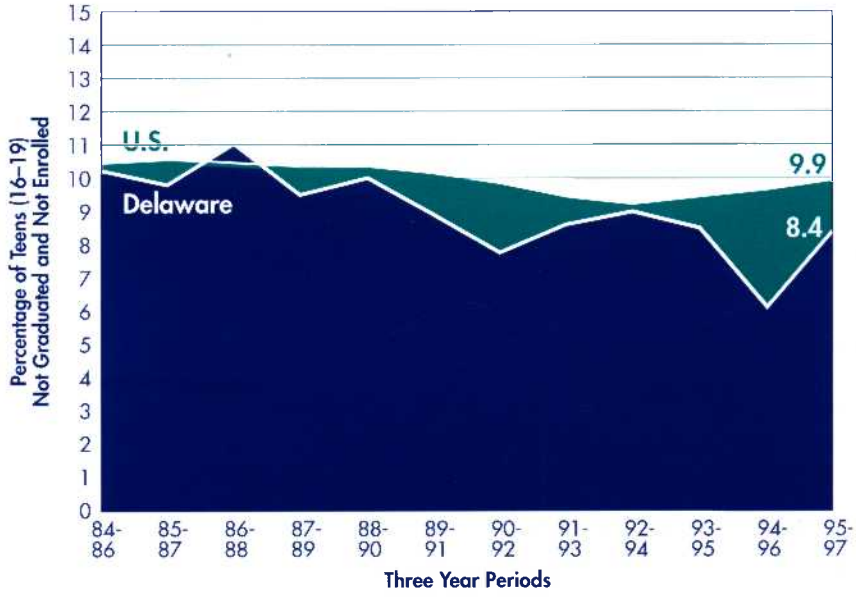
Teens Not Graduated and Not Enrolled – percentage of youths 16–19 who are not in school and not high school graduates

For more information see

Teen Births, Did You Know	p. K-13
Infants Deaths by Education of the Mother	p. K-23
Teens Not in School and Not Working	p. K-32
Suspensions and Expulsions	p. K-33
Table 20	p. K-69
Tables 38–45	p. K-78–81
In the FAMILIES COUNT Section:	
Teens Not in School and Not Working	p. F-28
High School Dropouts	p. F-29

Teens Not Graduated and Not Enrolled

Teens 16–19 Years Old
Delaware Compared to U.S.



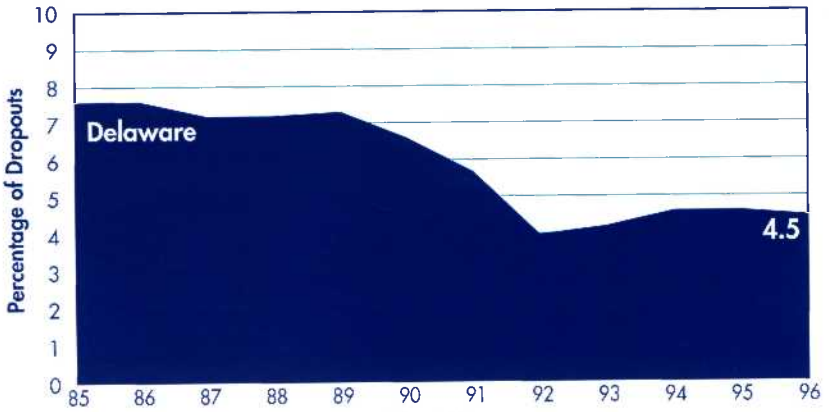
Note: Variations in the Delaware graph are due to sampling size of the data collection. Data are collected through a sample size too small for county breakout.

This measure is based on an analysis of the Current Population Survey, representing a nationwide sampling. Like all estimates derived from sampling, these figures do contain sampling errors. The Bureau of Labor Statistics suggests that state rankings based on these figures should be used with caution.

Source: Center for Applied Demography and Survey Research, University of Delaware

Public High School Dropouts

Grades 9–12, Delaware

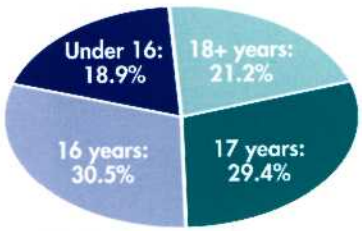


This data, provided by the Delaware Department of Education, reports information from the state's secondary schools. Delaware is one of the states that currently has the capability to maintain a complete dropout database at the state level which contains individual student records, rather than aggregate counts.

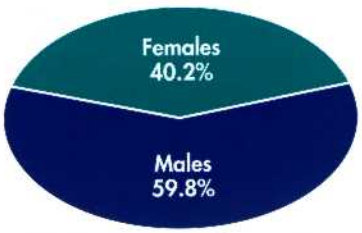
Source: Delaware Department of Education

Percentage of Dropouts

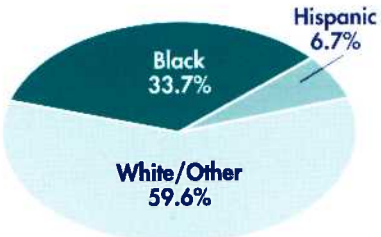
by Age, Gender, and Racial/Ethnic Group



% of all dropouts by age



% of all dropouts by gender

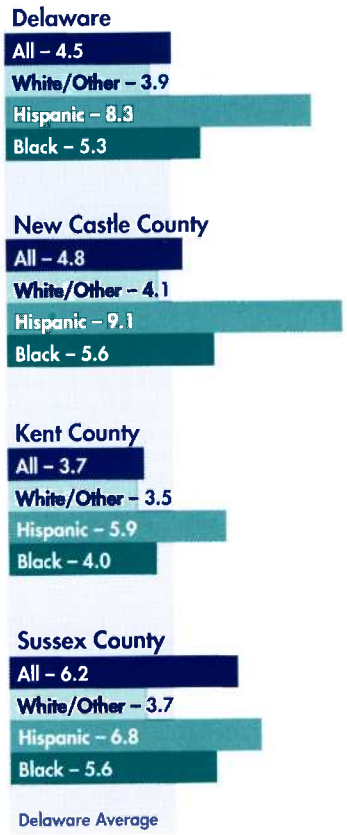


% of all dropouts by racial/ethnic group

School Year 1995–1996
Source: Delaware Department of Education

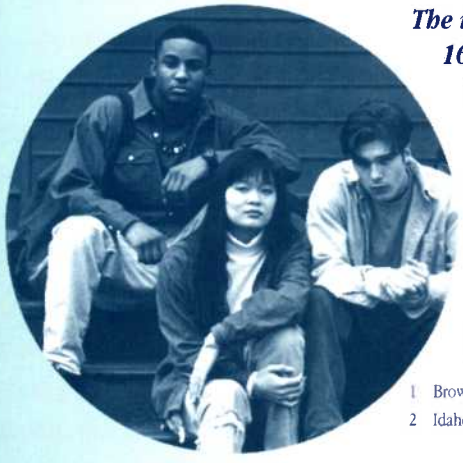
Dropout Rates

by Racial/Ethnic Group



School Year 1995–1996
Source: Delaware Department of Education

Teens Not in School and Not Working



The indicator "teens not in school and not working" is defined as youth ages 16–19 who are not enrolled in school and are unemployed. This indicator includes recent high school graduates who are unemployed and teens who have dropped out of high school who are jobless. Teens who are not in school or working for extended periods of time become disconnected from society because they are not involved in any of the key activities that are critical to development [1]. They are at increased risk for juvenile delinquency, substance abuse, crime victimization, teenage pregnancy, and poverty. Few skills and little education present significant barriers in finding and keeping a job later in life [2].

1 Brown, B. V. (1996, March). Who are America's disconnected youth? *American Enterprise Institute.*

2 Idaho KIDS COUNT. (1996). *Idaho KIDS COUNT Data Book: 1996,* 31-32.

Definition:

Teens Not in School and Not Working – percentage of teenagers 16–19 who are not in school and not employed

For more information see

High School Dropouts p. K-30

Tables 38–45 p. K-78–81

In the FAMILIES COUNT Section:

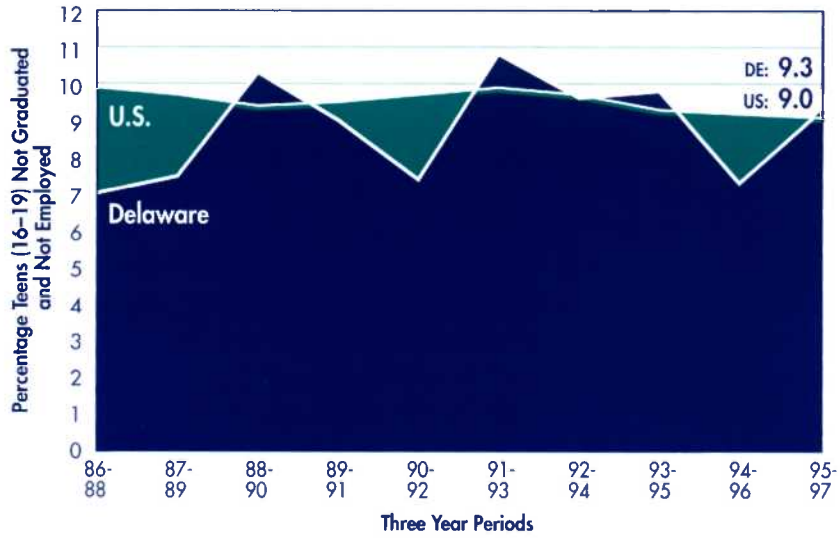
Teens Not in School and Not Working p. F-28

High School Dropouts p. F-29

Unemployment p. K-46

Teen Not in School and Not Working

Delaware Compared to U.S.



Note: Variations in the Delaware graph are due to sampling size of the data collection. Data are collected thraugh a sample size too small for county breakout.

This measure is based on an analysis of the Current Population Survey, representing a nationwide sampling. Like all estimates derived from sampling, these figures do contain sampling errors. The Bureau of Labor Statistics suggests that state rankings based on these figures should be used with caution.

Source: Center for Applied Demography and Survey Research, University of Delaware

Suspensions and Expulsions

The State of Delaware's Department of Education keeps track of out-of-school suspensions and expulsions in all regular, vocational/technical, and special public schools for each school year. During the 1995-96 school year, a total of 23,777 out-of-school suspensions were reported by Delaware's 19 school districts. Three percent of these suspensions occurred in grades K-3. About 45% of the suspensions were students from grades 4–8 and the remaining 52% of suspensions happened in the high school level, grades 9–12. Suspensions were the result of various infractions, including fighting (16%) and defiance of authority (12%). Approximately 307 students were absent each day due to suspensions totaling about 55,300 days missed. The number of students involved in the incidents which resulted in suspension was 11,650, of which 68% were male.

It is important to understand that the duration of out-of-school suspensions is influenced by district policy, district procedure, severity of the incident, frequency of a particular student's involvement in disciplinary actions, and the availability of discipline alternatives.

Suspensions in Delaware Schools, 1995/96

County	Number of Suspensions	Number of Students Who Were Suspended	Enrollment	Percentage of Enrollment Who Were Suspended
Delaware	23,777	11,650	107,791	11%
New Castle	15,934	7,701	63,093	12%
Kent	3,525	1,976	24,343	8%
Sussex	4,318	1,973	20,355	10%

Source: Delaware Department of Education

Expulsions in Delaware Schools, 1995/96

County	Number of Expulsions	Enrollment	Percentage of Enrollment Who Were Expelled
Delaware	120	106,813	0.1%
New Castle	78	62,414	0.1%
Kent	16	24,257	>0.1%
Sussex	26	20,142	0.1%

Source: Delaware Department of Education

Children in Poverty

Poverty is related to all of the KIDS COUNT indicators. It is defined as the condition of not having enough income to meet basic needs for food, clothing, and shelter[1]. The 1996 poverty threshold for a family of four was $15,911 per year. Poverty affects children through inadequate nutrition, fewer learning experiences, residential instability, poor quality of schools, exposure to environmental toxins and family violence, dangerous streets, and reduced access to a support network[1]. The price of poverty is passed on to society by the effect on its schools, hospitals, and criminal justice system[2]. Poverty affects many; one third of U.S. children will be poor for at least one year of their childhood. For some, the impoverishment will stretch across childhood and reach into their adult years[3].

1 Future of children: the effects of poverty on children. (1997, Summer-Fall) *The Center of the Future of Children,* 7(2).

2 Children's Defense Fund (1998). *The State of America's Children Yearbook 1998.* Washington D. C.

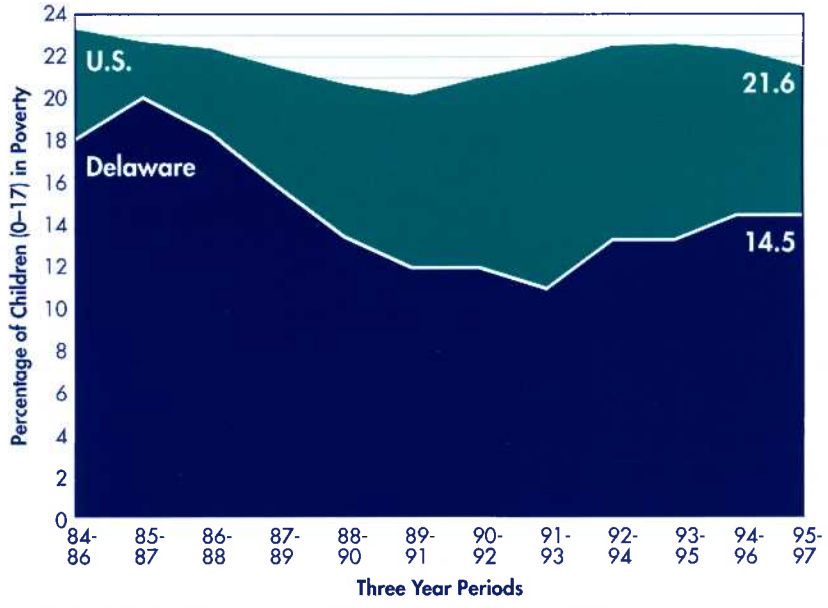
3 Future of children: dynamics of childhood poverty. (1997, Summer-Fall). *The Center of the Future of Children,* 7(2).

Definition:

Children in Poverty – percentage of children in poverty; in 1996 the poverty threshold for a one-parent, two child family was $12,641. For a family of four with two children, the threshold was $15,911.

Children in Poverty

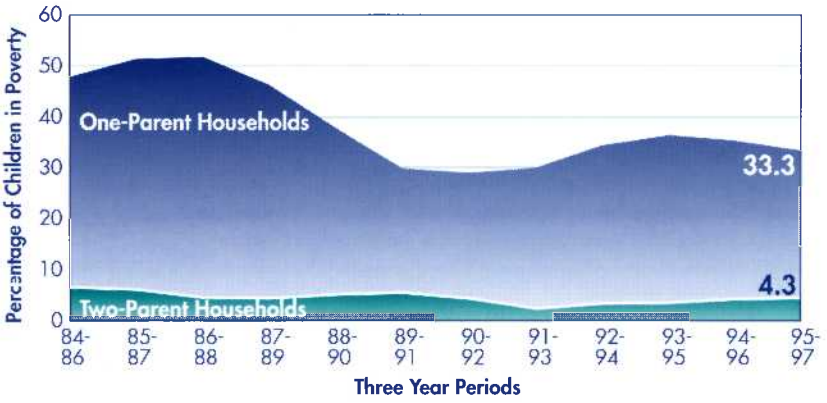
Delaware Compared to U.S.



Source: Center for Applied Demography and Survey Research, University of Delaware

Children in Poverty by Household Structure

Delaware



Source: Center for Applied Demography and Survey Research, University of Delaware

Did you know:

The **frequency of health problems** is higher in low-income children compared to other children. Relative frequencies of health problems of low-income children compared with other children in the U.S. are listed below.

Health Problem	Relative Frequency in Low-income Children
Low birth weight	double
Delayed immunization	triple
Asthma	higher
Bacterial meningitis	higher
Rheumatic fever	double to triple
Lead poisoning	triple
Neonatal mortality	1.5 times
Postneonatal mortality	double to triple
Child deaths due to accidents	double to triple
Child deaths due to disease	triple to quadruple
Complications of appendicitis	double to triple
Diabetic ketoacidosis	double
Complications of bacterial meningitis	double to triple
Percent with conditions limiting school activity	double to triple
Lost school days	40% more
Severely impaired vision	double to triple
Severe iron-deficiency anemia	double

Source: Colorado KIDS COUNT Data Book; B. Starfield, "Child and Adolescent Health Status Measures," The Future of Children, Vol. 3 No. 2, Winter 1992

For more information see

Teen Births, Did You Know p. K-13

Median Income of Families by Family Type p. K-37

Child Care Costs p. K-39

Subsidized Child Care p. K-40

Children Receiving Free and Reduced Price School Meals p. K-42

Women and Children Receiving WIC p. K-43

Children without Health Insurance p. K-45

Tables 46–57 p. K-81–85

In the FAMILIES COUNT Section:

Health Care Coverage p. F-19

Children in Poverty p. F-32

Female Headed Households in Poverty p. F-36

Child Support p. F-37

Risk of Homelessness p. F-38

Health Care Coverage p. F-39

Unemployment p. F-46

Substandard Housing p. F-52

Home Ownership p. F-53

Children in One-Parent Households

Children who live with one parent are much more likely to be living in poverty than children who live with two parents [1]. The risk is increased when the single parent is female due to the wage gap because of the type of job a woman is likely to have [2]. Delaware women, like their national counterparts, occupy a higher proportion of lower-paying occupations (such as sales, clerical, and service positions) than do men [3]. Census Bureau data reveal that in 1996, almost half (49%) of all children in families headed by single mothers were below the poverty threshold [1].

1 Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998*. Washington D. C

2 Ellwood, D. T. (1988). *Poor Support: Poverty in the American Family* New York: Basic Books.

3 Office of Occupational and Labor Market Information: Delaware Occupational Information Coordinating Committee. (1997). *Delaware Women: Where are they Working?*

Definition:

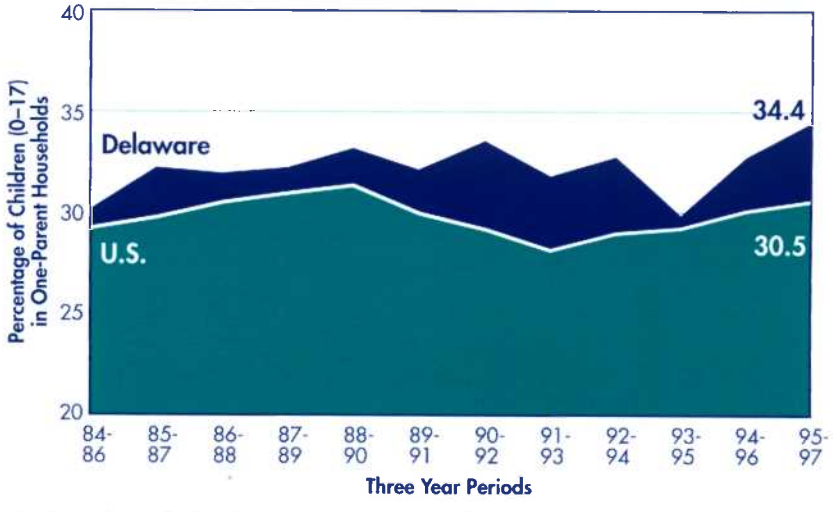
Children in One-Parent Households – percentage of children living with one parent.

For more information see

Birth to Unmarried Teens	p. K-15
Infant Mortality by Marital Status of Mother	p. K-23
Children in Poverty by Household Structure	p. K-35
Table 7	p. K-60
Table 20	p. K-69
Table 46	p. K-81
Tables 54–59	p. 84–86
In the FAMILIES COUNT Section:	
One-Parent Households	p. F-33
Female Headed Households in Poverty	p. F-36
Child Support	p. F-37

Children in One-Parent Households

Delaware Compared to U.S.



Source: Center for Applied Demography and Survey Research, University of Delaware

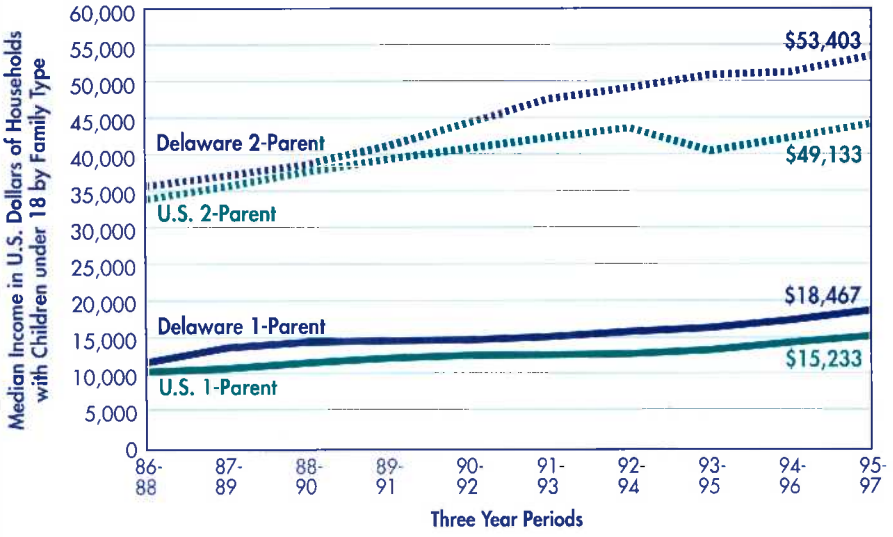
Did you know:

- Children of never married mothers are twice as likely (59%) to have their moms **unemployed** or not in the labor force as children whose mothers were divorced (29%).
- 85% of divorced parents **finished high school**; fewer than two-thirds of never-married parents finished high school.
- Nationally, **18.9 million children** under 18 lived with one parent in 1995.
  - 38% of parents were divorced
  - 35% of parents were never married
  - 19% of parents were separated
  - 4% of parents were widowed
  - 4% of parents had spouses who lived elsewhere

Source: Single-parent kids fair better if parent is divorced, rather than never married: census data show. (1997, December 8). Jet, 93 (1), p. 48.

Median Income of Families with Children by Family Type

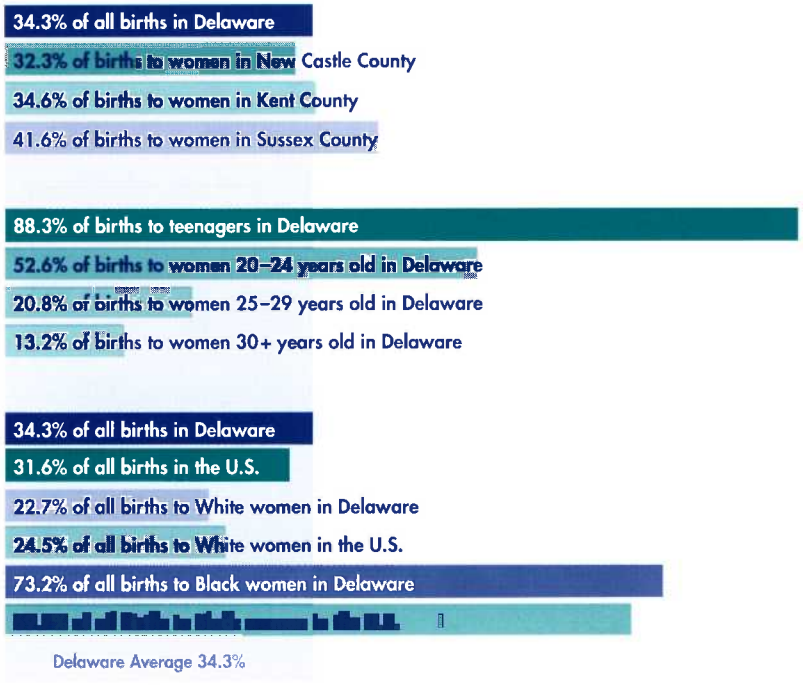
Delaware and U.S.



Source: Center for Applied Demography and Survey Research, University of Delaware

Percentage of Births to Single Mothers

in Delaware by County, Age, and Race
Five-year Average, 1992–96



Source: Delaware Health Statistics Center

Early Care and Education

Child care has become a fundamental need for Delaware families over the past two decades. In 1995, 73% of Delaware children under age 6 and 58% of children ages 6–12 had working parents [1]. In these families, finding appropriate, affordable and accessible child care becomes a critical task, often beginning in the first weeks or months of life and continuing through the school-age years. Delaware is not unique in this situation; as the child care system throughout the United States faces many challenges that must be addressed for the benefit of our children.

One obstacle that many working parents encounter is the limited availability of affordable child care. Even when cost is not an insurmountable barrier, many families find that child care is simply not available at the times and places it is needed. Additionally, unregulated providers and a lack of national standards contribute to mediocrity in some child care settings. The consequences of poor quality child care are of enormous concern, especially for at-risk children. Increasingly, studies show the importance of stimulating cognitive skills in young children as early as possible. Addressing the income needs of child care workers would go a long way towards encouraging continuity of the staff and a sense of value in the community. At the present time, low wages for child care providers add to a turnover rate three times higher than the nation's average turnover rate for other occupations. Finally, recent changes in welfare laws linking cash assistance to work or participation in work-readiness programs will mean additional children in need of quality child care in the coming years.

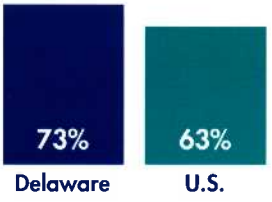
1 Annie E. Casey Foundation (1998) *KIDS COUNT Data Book: 1998* p. 54.

For more information see

Table 47	p. 81
Tables 61–62	p. 87–88
In the FAMILIES COUNT Section:	
Early Intervention	p. F-26
Head Start	p. F-27

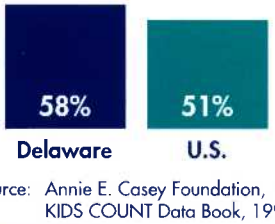
Need for Care

Percent of children under 6 living with working parents, 1995



Source: Annie E. Casey Foundation, KIDS COUNT Data Book, 1998

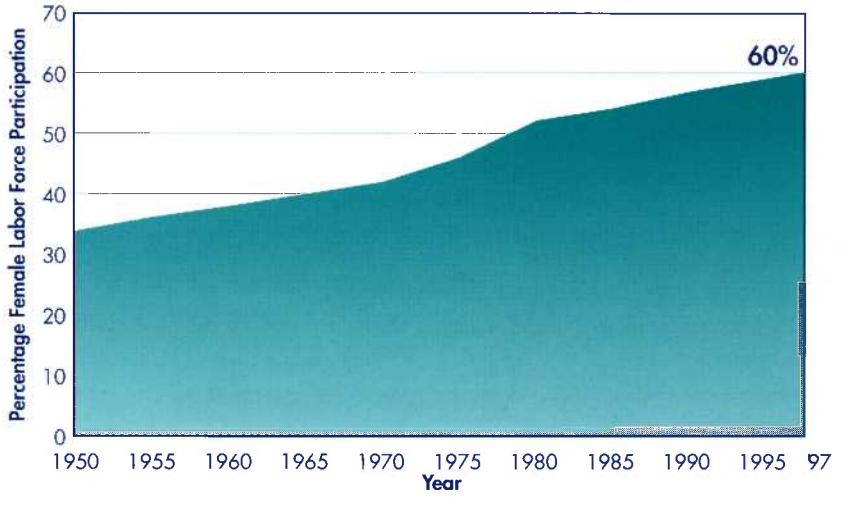
Percent of children ages 6–12 living with working parents, 1995



Source: Annie E. Casey Foundation, KIDS COUNT Data Book, 1998

Women in the U.S. Labor Force

Percentage of Women in the Labor Force



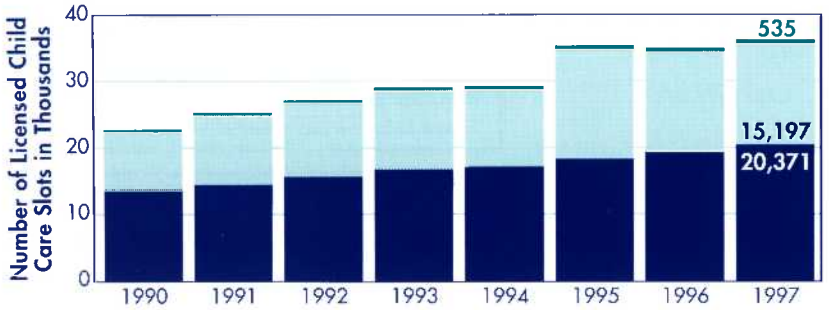
Source: Annie E. Casey Foundation, KIDS COUNT Data Book, 1998

Accessibility

Licensed child care in Delaware is available in three settings: child care settings, family child care homes, and large family child care homes. The availability of child care through informal arrangements such as relative or neighbor care, part time care, or unlicensed care is unknown at this time. Anecdotal information points to a need for more care in Delaware, however, actual statistics are unavailable.

Available Child Care

Delaware



Child Care Centers – 13 or more children
Family Child Care Homes – 1 person caring for no more than 6 children
Large Family Child Care Homes – 2 people caring for 7–12 children

Source: Delaware Department of Services for Children, Youth and Their Families

Definitions:

Percent of children under age 6 living with working parents – reflects the share of preschool children who are likely to need child care. For this group of children, "working parents" are defined as those parents who reported that they usually worked at least 1 hour per week in the previous calendar year.

Percent of children ages 6-12 living with working parents – reflects the share of elementary school-age children who are likely to need child care. For this group of children, "working parents" are those parents who reported that they usually worked at least 30 hours per week in the previous calendar year. Thirty hours per week was selected as the threshold because most kids are in school for about that amount of time when school is in session, allowing their parents to work.

Working parents – for children in single-parent families, the work criteria are applied to that parent. For children in married-couple families, the work criteria are applied to both parents.

Affordability

The cost of full-time child care often represents the largest expense, after housing, for working parents who need full time care for their children. The less families earn, the higher the proportion of income spent on child care[1].

1 Phillips, D. and Bridgman, A., eds. (1995). New findings on children, families, and economic self-sufficiency. Board on children and families, National Research Institute, Institute of Medicine.

Child Care Costs

Weekly Cost in Dollars to Families for Child Care by Child's Age
Delaware and Counties, 1997

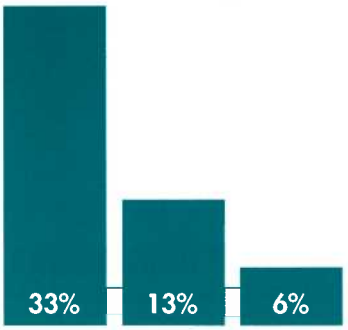
Age	Child Care Centers Minimum	Average	High	Family Child Care Homes Minimum	Average	High
New Castle						
0–12 months	67	125	190	55	97	175
1 and 2 years old	67	108	185	53	82	175
3 years and older	46	98	180	42	56	162
Kent						
0–12 months	63	84	144	50	72	125
1 and 2 years old	59	76	115	50	69	90
3 years and older	54	74	112	42	66	90
Sussex						
0–12 months	53	82	105	35	68	100
1 and 2 years old	53	72	97	35	65	93
3 years and older	46	67	93	32	61	92

Source: The Family and Workplace Connection

Continued on next page

Child Care Costs

Proportion of Income Spent by Family Income Level, U.S. 1990



Source: 1997 Rhode Island KIDS COUNT Factbook

Early Care and Education

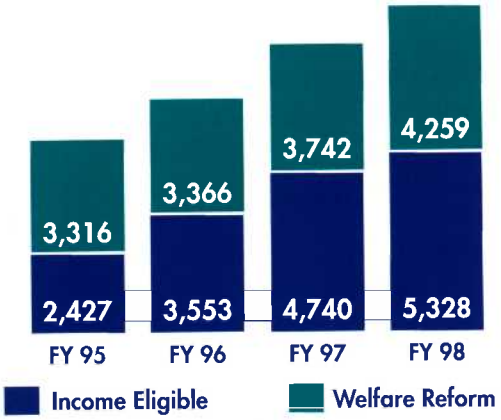
Continued from previous page

Children in poor families have a greater need for more comprehensive and high quality child care services. Studies show that children in poor families are nearly one-third more likely to suffer from delays in growth and development, a learning disability, or a significant emotional or behavioral problem[2].

2 Rhode Island KIDS COUNT. (1997, October). Child care in Rhode Island: Caring for infants and preschool children. Issue Brief

Subsidized Child Care

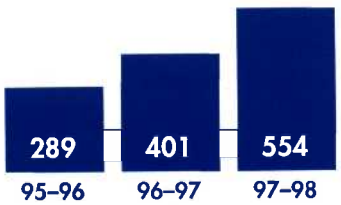
Children Served in Delaware
Projected Monthly Averages



Source: Delaware Department of Education

Early Childhood Assistance Program

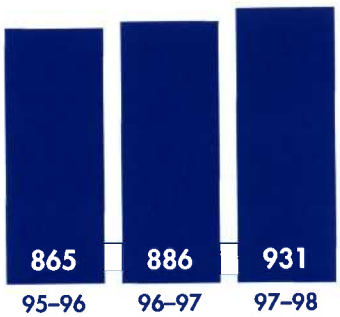
Number of Children Funded in Delaware



Source: Delaware Department of Education

Head Start

Children Served in Delaware



Source: Delaware Department of Education

Head Start is a comprehensive early childhood development program for low-income preschool children and their families. The Early Childhood Assistance Program in Delaware provides funding for four-year olds who meet the eligibility criteria for Head Start programs. Both programs are designed to provide low-income children with the socialization and school readiness skills they need to enter public schools on an equal footing with more economically advantaged children[3].

3 Children's Defense Fund. (1995). The State of America's Children Yearbook: 1995. Washington, D.C.

Staff/Child Ratios

Licensing Requirements vs. Accreditation Recommendations Staff to Child Ratios

Age of Child	# Children Allowed per Caregiver in Delaware	NAEYC Recommended Level
9 month	4	3–4
18 month	7	3–5
27 month	10	4–6
3 years	12	7–10
4 years	15	8–10

Source: Children's Defense Fund. (1996, May). Delaware: child care challenges.

Accredited Programs in Delaware

as of 8-25-98

20 Centers
46 Family Child Care Providers

Source: The Family and Workplace Connection

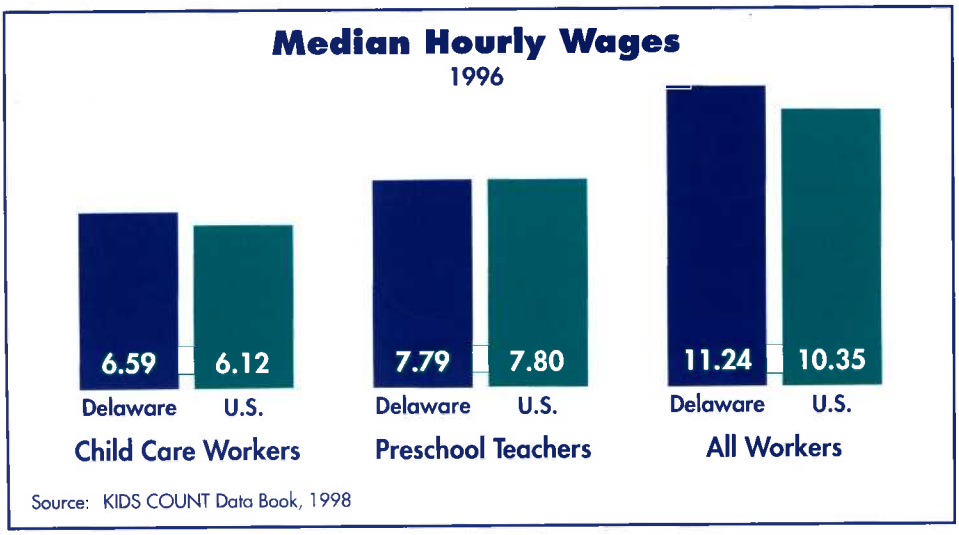
Quality

The quality of early child care has a significant impact on child well-being, ability to learn, and readiness for school. Quality child care nurtures the child and stimulates the developing brain[4]. One way to monitor quality is through accreditation.

4 Rhode Island KIDS COUNT. (1997, October). Child care in Rhode Island: Caring for infants and preschool children. Issue Brief.

Licensed child care programs meet the state's basic requirements for protecting children against harm. A license does not necessarily mean that a program has been inspected or that it meets standards of high quality.

Accredited child care programs meet standards of quality established by nationally recognized professional organizations. For example, The National Association for the Education of Young Children (NAEYC) offers accreditation for center-based programs; The National Association of Family Child Care (NAFCC) offers accreditation to family child care providers. Accreditation does not guarantee that a program is better than one that has not applied for accreditation, but it does mean the program has a strong interest in quality and has met national standards higher than licensing.



Low wages associated with the child care profession contribute to a turnover rate close to three times the national average for other occupations. This high staff turnover rate interferes with the bonding of children to caregivers[5].

5 Financing day care: analysis and recommendations. (1996). The Future of Children, 6. (2), pp. 5-25.

School Age Care

The problems and temptations that school age children face when they are left unsupervised are alarming. Studies indicate that children who are left unsupervised have higher absentee rates at school, have lower academic test scores, exhibit higher levels of fear, stress, nightmares, loneliness, and boredom, are 1.7 times more likely to use alcohol, and are 1.6 times more likely to smoke cigarettes[6]. High quality after school programs, staffed by trained, caring adults, can have a measurably positive effect on children. These types of programs can help meet the critical child care needs of working families and their children. Programs based in schools are highly desirable for a number of reasons. Schools exist in every community and offer valuable resources that could be utilized to provide after school programs. And because children are already at school, there is no transportation needed in the middle of the day[7].

6 Growing up with someplace to go: providing care for school age children. Available: http://www.ci.seattle.wa.us/most/growup.htm/

7 National PTA. (1998, April). Before- and after- school care.

Consumer Awareness

One of the most challenging tasks facing new parents is arranging for care for their babies. Parents who need or want child care services have to choose among public, nonprofit, private agencies, religious or secular care, out-of-home child care centers or family child care homes. With so many decisions to make, parents may need help recognizing the components of a high-quality program. Parents may also need help obtaining objective information about programs so that they can assess the alternatives[8]. The Family and Workplace Connection is one of the agencies in Delaware that informs parents of their child care options.

8 Annie E. Casey Foundation. (1998). Child care you can count on: consumer awareness.

Child Care Referrals

Number of annual calls to Family and Workplace Connection
1997

Approximately	10,000

Source: The Family and Workplace Connection

Children Receiving Free and Reduced Price School Meals

Research has consistently shown a relationship between poverty, poor nutrition, and educational development in children. The Food Research and Action Center reports that hungry children are inattentive in class, likely to have discipline problems, and perform poorly in problem-solving activities [1].

Children who have adequate nourishment are more active and social on the playground, more focused in class, and better able to think and remember what they have learned. When children do not master academic skills and fall behind in school, their chances to develop their potential as students, lifelong learners, and productive members of society decrease.

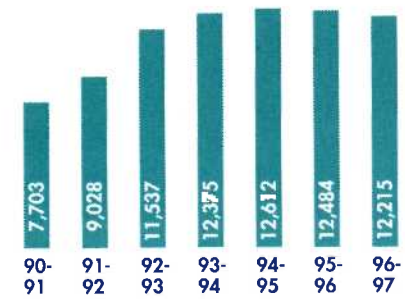
1 Action Alliance for Children. (1997, November-December). Healthy meals = healthy kids. Available <http://www.4children.org>.

For more information see

Children in Poverty	K-34
Women and Children Receiving WIC	p. K-43
Health problems in low-income children	p. K-35
Tables 48–49	p. K-82
In the FAMILIES COUNT Section:	
Children in Poverty	p. F-32

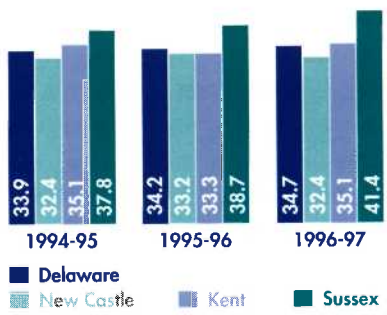
The National School Lunch and School Breakfast Programs provide nutritious meals to children at participating schools. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Medicaid households are automatically eligible for free meals. Participation levels in this program, however, are affected by a variety of factors such as the level of outreach in the school community and the extent to which children are stigmatized as participants. Although not every eligible student participates, the number of children receiving free or reduced-price meals can indicate the number of low-income children in a school district.

Free and Reduced Price Breakfasts
Average Number Served Daily



Source: Delaware Department of Education

Free and Reduced Price Lunches
as a Percentage of Total Enrollment



Source: Delaware Department of Education

Did you know:

- Children participating in the National School Lunch Program get between one third and one half of their total nutrients each day from this meal.
- Only one in six children who participate in the National School Lunch Program participate in the Summer Food Service Program for Children (created by Congress in 1968).
- The American Academy of Pediatrics says children are the best judges of how much they should eat; parents are the best judges of what they should eat.

Source: Children of summer. Available HYPERLINK http://www.kidscampaigns.org/Hot/summer/html

Women and Children Receiving WIC

The Special Supplemental Food Program for Women, Infants, and Children (WIC) is a preventative nutritional program which provides food supplements, nutrition education, and access to health care. Users of this service are low income women who are pregnant, postpartum, and breast-feeding, and their infants and children to age five.

WIC foods are specifically chosen to provide protein, iron, calcium, and vitamins A and C. These vitamins and minerals are likely to be missing from the diets of low-income women and children. While the USDA estimates that WIC serves approximately 5.8 million participants each month*, the number represents only about 60% of those eligible.

The General Accounting Office (GAO) has released a report detailing a significant cost savings resulting from the ability of WIC to reduce the number of low birth weight births. This reduction benefits both public and private sector business by lowering medical costs, special education costs, and SSI payments for disabled children. The GAO estimates a savings of $853 million in health related expenses for WIC infants in their first year of life and a $1.036 billion savings over 18 years [1].

* For the year 1993.

1 Special Supplemental Food Program for Women, Infants, and Children (WIC) fact sheet. Available <http://www.handsnet.org/>.

For more information see

Children in Poverty	K-34
Children Receiving Free and Reduced Price School Meals	p. K-42
Health problems in low-income children	p. K-35
Tables 48–49	p. K-82
In the FAMILIES COUNT Section:	
Children in Poverty	p. F-32

WIC Program

Average Number Served per Month Delaware, 1996

Infants	4,414
Children 1–4	8,353
Mothers	3,230

Source: Division of Public Health, WIC Office

WIC Program

Total Number Served Delaware, 1996

In 1996, approximately 19,000 infants and children were served by WIC in the State of Delaware.

Over 41% of all infants born in 1996 in Delaware used the services of WIC in that year.

Source: Division of Public Health, WIC Office

Did you know:

- Even a few months of malnutrition can damage a child's developing brain, reducing mental capacity and impacting the child for life.
- At least four million American children under age 12 are hungry and another 9.6 million are at risk for hunger (hunger is defined as insufficient food due to limited household resources).
- Four- and five- year olds who participate in WIC in early childhood have better vocabularies and memory scores than comparable (family income status) children who do not participate in WIC.

Source: Children of summer. Available HYPERLINK http://www.kidscampaigns.org/Hot/summer/html

Asthma

Asthma is one of the most common chronic conditions affecting children. Despite major advances in treatment, morbidity and mortality rates in pediatric asthma have risen over the past two decades. These increases have disproportionately affected children living in poverty. Inadequately controlled asthma often has negative effects on the quality of life of children and their families and may result in the failure of children to reach their full potential as adults. School and job attendance, school performance, participation in physical activities, peer group and family relationships, and behavioral and emotional development may all suffer due to this condition. Asthma is also a major contributor to health care costs for children and adults.

Definition:

Readmissions – Number of asthma inpatient hospital admissions for children 0–17 who had previously been discharged with a diagnosis of asthma in the same year

Discharge Rate – Number of inpatient asthma discharges for children 0-17 per 1,000 children in the same age group

Readmission Rate – Number of inpatient asthma readmissions for children 0-17 per 100 children previously admitted in the same year

For more information see

Child Deaths	p. K-24
Health problems in low-income children	p. K-35
Children without Health Insurance	p. K-45

In the FAMILIES COUNT Section:

Child Deaths	p. F-18
Health Care Coverage (Children)	p. F-19
Health Care Coverage (Families)	p. F-39

Hospitalizations for Childhood Asthma

Inpatient Asthma Discharges for Children 0–17 years of age by health insurance status, Delaware Hospitals, 1995

	Children Discharged	Readmissions	Total Discharges	Discharge Rate	Readmission Rate
Delaware	570	104	674	3.9	18.2
Medicaid	278	69	347	6.4+	24.8+
Non-Medicaid	292	35	327	2.9	12.0

Note: + indicates that the Medicaid rate is statistically higher than the Non-Medicaid rate
Source: Delaware Health Statistics Center

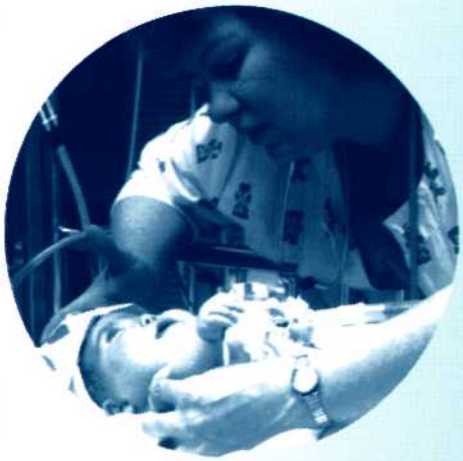
Hospitalization rates are one measure of morbidity associated childhood asthma. The table above shows 1995 Delaware hospitalization data for childhood asthma. More than half of the 674 hospitalizations involved Medicaid children despite the fact that only 31% of Delaware children were Medicaid eligible in 1995. Hospitalization for asthma overall and readmission of the same child during this period occurred at over twice the rate among Medicaid children compared with non-Medicaid children.

These data indicate that Delaware Medicaid children suffer excess asthma morbidity as measured by the need for hospitalization. Several factors have been implicated in contributing to this problem, including health care access barriers associated with poverty, lack of patient/family knowledge about the condition and its management, and environmental asthma "triggers" such as the recently recognized role of cockroach antigen exposure in increasing the severity of asthma among low-income inner-city children.

Asthma experts believe that the majority of childhood asthma hospitalizations, as well as other morbidity associated with the condition could be prevented with appropriate management of the disease, including patient/family education, medications, and environmental control. KIDS COUNT in Delaware will continue to follow this indicator of childhood asthma morbidity, with particular interest in the possible impact of Medicaid managed care, child health insurance coverage expansion programs and other health care reform initiatives in Delaware.

Children without Health Insurance

Children who do not have health insurance are much less likely to be taken to a doctor when they appear sick than children who do have health insurance [1]. Lack of health insurance decreases the likelihood that a child will have a single primary care physician and when children are under three, increases the risk that they are not being vaccinated or screened for developmental disorders [2]. Additionally, uninsured children are likely to use hospital emergency rooms for care with conditions that could have been easily treated or prevented at a fraction of the cost [3].

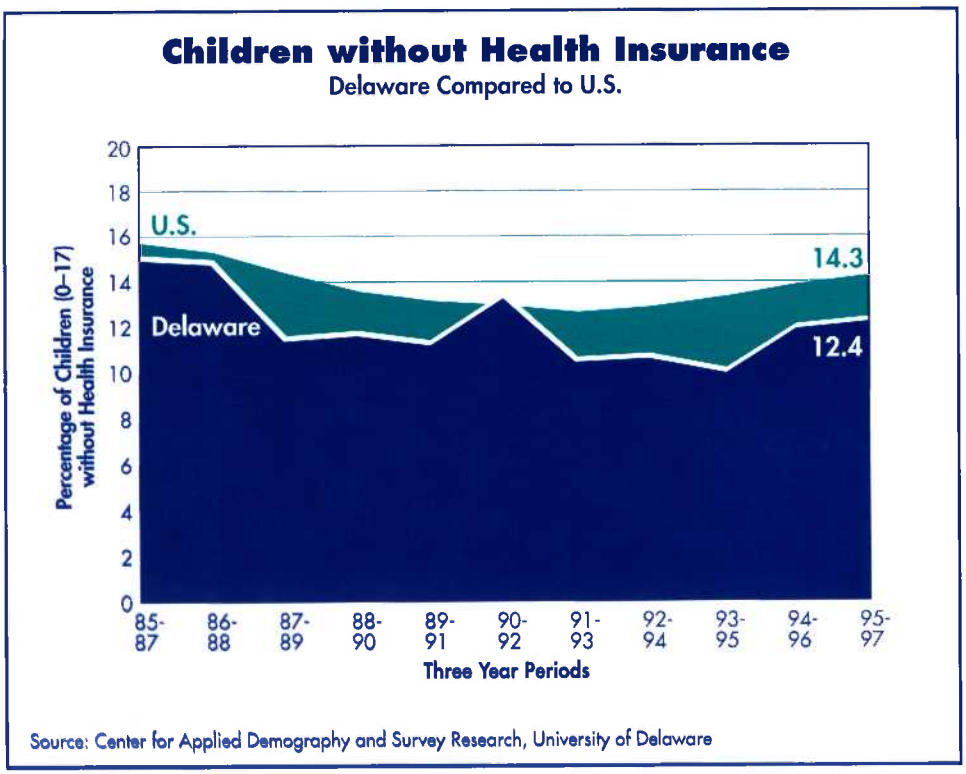


In Delaware, the Delaware Healthy Children Program was created with funds from the Balanced Budget Act of 1997. Beginning in January, 1999, the plan will allow every uninsured child with a family income below 200% poverty to obtain a high quality, low cost health care policy. Ten thousand- five hundred Delaware children will be eligible to benefit from this new program.

1 Stoddard, J. J., St. Peter, R. F., and Newacheck, P. W. (1994, May 19). Health insurance status and ambulatory care for children. *The New England Journal of Medicine, 330* (20), 1421-1425.

2 Kogan, M D., Alexander, G. R., Treitelbaum, M. A., Jack, B. W, Kotelchuck, M., Pappas, G. (1995, November 8). The effects of gaps in health insurance on continuity of a regular source of care among preschool-aged children in the United States. *The Journal of the American Medical Association, 274* (18), 1429-1435.

3 Leif, L. (1997, April 28). Kids at risk: uninsured children increasingly come from middle-class families. *U.S News and World Report 122* (16), 66-69.



For more information see

Child Deaths	p. K-24
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Health problems in low-income children	p. K-35
Asthma	p. K-44

In the FAMILIES COUNT Section:

Child Immunizations	p. F-17
Child Deaths	p. F-18
Health Care Coverage (Children)	p. F-19
Health Care Coverage (Families)	p. F-39

Alcohol, Tobacco, and Other Drugs

Most teenagers will have some experience with drugs. Many of these teens will experiment and stop or continue to use casually without significant problems. Some will use regularly, with varying degrees of physical, emotional, and social problems. Others will develop a dependency and be destructive to themselves and others for many years. Some will die. Some will cause others to die [1].

While all teens are at risk for experimenting with drugs, those who are at increased risk are the nearly five million school-age children left home alone each week. Teens who are unsupervised for hours each day (after school before their parents return home from work) are likely to participate in risky behavior, including substance abuse [2].

Substance abuse in teens can cause changes in personality such as moodiness, irresponsible behavior, low self-esteem, depression, and a general indifferent attitude. Physically, a teen may experience fatigue, red and dull eyes, a steady cough, and repeat health problems. While at school substance abuse causes absences, grades to drop, and discipline problems [1].

For more information see

Student Violence and Possession p. K-29

Tables 29–31 p. K-73–74

In the FAMILIES COUNT Section:

Substance Abuse p. F-20–21

1 Teens: alcohol and other drugs. *American Academy of Child and Adolescent Psychiatry.* Available <http://www.mhnet.org>.

2 Children's Defense Fund. (1998) *The State of America's Children Yearbook 1998.* Washington D. C.

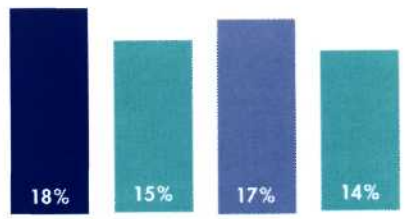
In *Kids Voices Count: Listening to Delaware's children talk about tobacco*, a joint publication of KIDS COUNT in Delaware and Tobacco Free Delaware, journalism students from Glasgow High School interviewed children from around the state. Here is some of what they heard:

- "To prevent even more smokers, groups should hit kids young, like third grade. It's to the point where fifth and sixth graders are smoking."
- "I feel like my athletic endeavors counteract the unhealthiness of the cigarettes."
- When I asked her if the effects can be reversed, she simply replied, "vinegar clears out everything."
- Jane* told me that she doesn't consider tobacco as dangerous as other drugs like cocaine or heroin because the damage it causes is not as extensive.
- "I did it [tried smoking] when I was 11 because it was something to do."
- Do you think that you will ever start [smoking]? "No, I'm gonna drink lots of beer instead."

Source: KIDS COUNT in Delaware and Tobacco Free Delaware. (1998). *Kids Voices Count: Listening to Delaware's children talk about tobacco*

* Not real name

Easy to Get Drugs
Among Delaware Fifth Graders, 1997

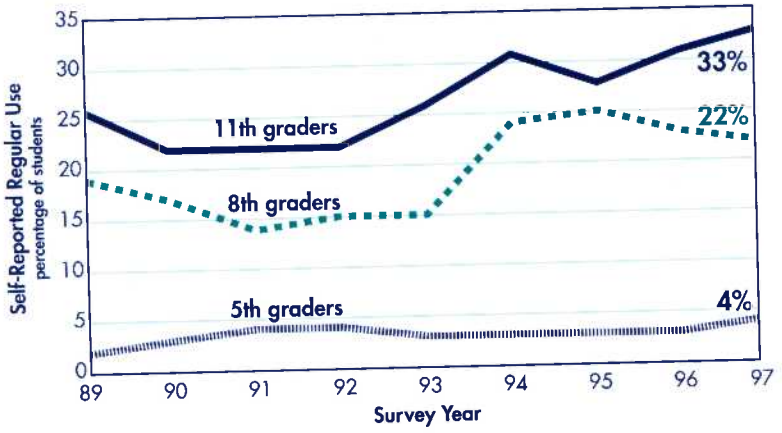


Percent of Delaware public school fifth graders who report ease of obtaining drugs

Sources: The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families

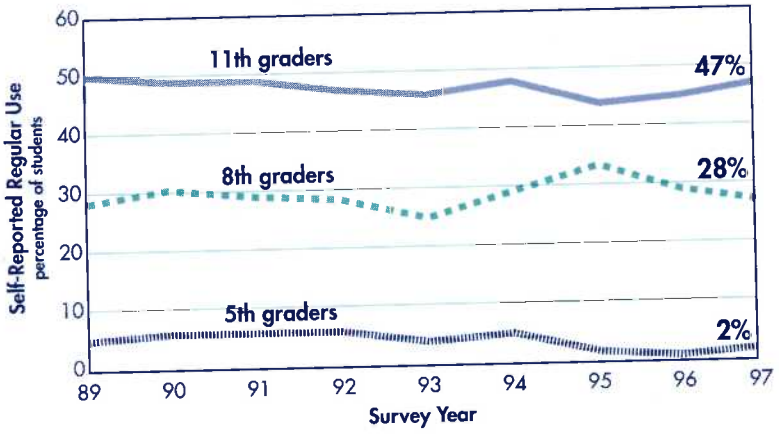
Trends in Cigarette Use

Students by Grade, Delaware, 1989–1997



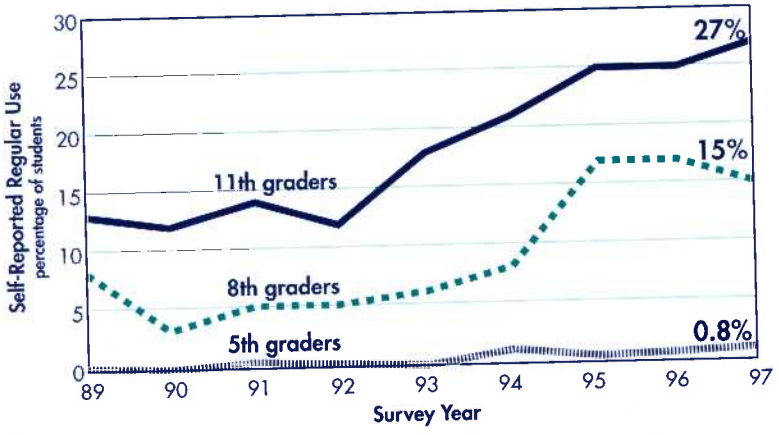
Trends in Alcohol Use

Students by Grade, Delaware, 1989–1997



Trends in Marijuana Use

Students by Grade, Delaware, 1989–1997



Sources: The Center for Drug and Alcohol Studies, University of Delaware and the Office of Prevention, Department of Services for Children, Youth and Their Families

Child Abuse and Neglect

Child abuse and neglect is all encompassing; it occurs in families without regard for socioeconomic status, race, or cultural background. Reports of child abuse and neglect increased 50% between 1985 and 1993 due to the rise in family poverty, the rise in substance abuse, and the decline in the amount of social services available to these families [1]. Child abuse and neglect causes immediate harm in the form of injury and has also been shown to have long-term effects. Research has shown that abuse and neglect is correlated with lack of school success, teenage pregnancy, juvenile delinquency, and social isolation [2,3].

1 Action Alliance for Children. (1995, July-August). *Fact Sheet: Child Abuse and Neglect.* Available <http://www.4children.org>.

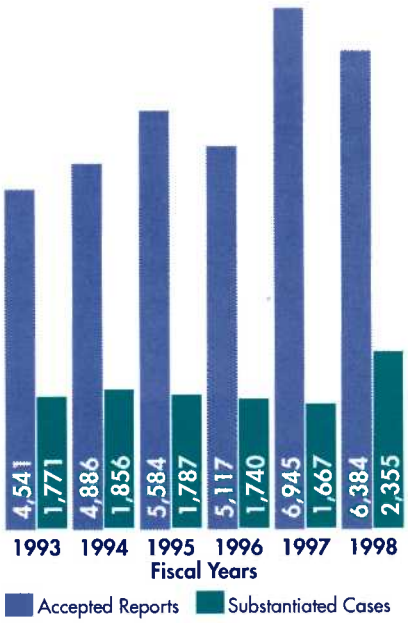
2 National Research Council. (1993). *Understanding Child Abuse and Neglect.* Panel on Research on Child Abuse and Neglect. Washington, D.C.: National Academy Press.

3 Loos, E. and Alexander, P. C. (1997, June). Differential effects associated with self-reported histories of abuse and neglect in a college sample. *Journal of Interpersonal Violence, 12*(3), 340-360.

For more information see

Child Abuse and Neglect

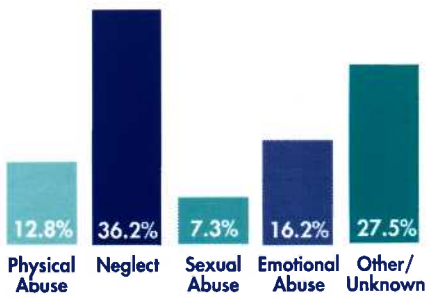
Accepted Reports & Substantiated Cases
Delaware, 1990–1998



Source: Department of Services for Children, Youth and Their Families

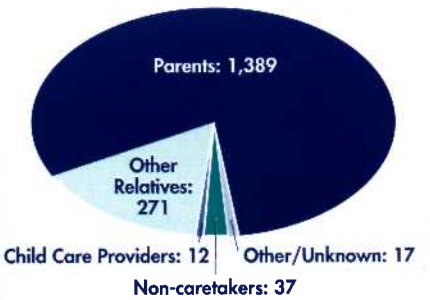
Breakdown of Substantiated Cases

Delaware, 1996



Who Are the Perpetrators?

Delaware, 1996



Sources :U.S. Department of Health and Human Services; Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, National Center on Child Abuse and Neglect

Foster Care

In the past few years, a variety of social and economic factors have led to an increased number of children who require out-of-home care. However, the large number of children entering foster care represents only part of the problem. Children entering care today are likely to have a number of emotional problems, behavioral problems, or physical handicaps. These children are likely to come from families with drug and alcohol abuse histories and are likely to have seen or been involved in domestic violence [1].

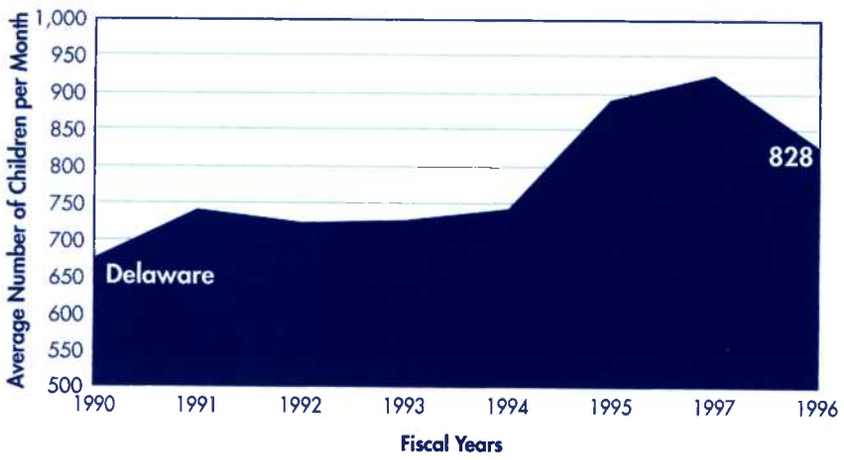
Being in foster care is correlated with a number of lifelong problems such as chronic health deficits, emotional challenges from the trauma of abuse and neglect, and difficulty in school [2]. Foster children have a low educational achievement level, experience disruption in education, and have trouble adjusting and performing in school [3].

1 David and Lucile Packard Foundation and Annie E. Casey Foundation. (1997). Current issues in foster care. *Take This Heart.*

2 Rosenfeld, A. A., Pilowsky, D. J., Fine, P., Thorpe, M., Fein, E., Simms, M. D., Halfon, N., Irwin, M., Alfaro, J., Saletsky, R., and Nickman, S. (1997, April). Foster care: an update. *Journal of the American Academy of Child and Adolescent Psychiatry, 36* (4), 448-457.

3 Blome, W. W. (1997, February). What happens to foster kids: educational experiences of a random sample of foster care youth and a matched group of non-foster care youth. *Child and Adolescent Social Work Journal, 14* (1), 41-53.

Foster Care
Delaware



Source: Delaware Department of Services for Children, Youth and Their Families, Division of Family Services

For more information see

Child Abuse and Neglect p. K-48

Table 64 p. K-89

In the FAMILIES COUNT Section:

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Juvenile Delinquents in Out-of-Home-Care p. F-44